OFFICE OF NATIONAL DRUG CONTROL POLICY: REAUTHORIZATION IN THE 115TH CONGRESS

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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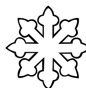

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OFFICE OF NATIONAL DRUG CONTROL POLICY: REAUTHORIZATION IN THE 115TH CONGRESS

Wednesday, July 26, 2017

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The committee met, pursuant to call, at 10:41 a.m., in Room 1100, Longworth House Office Building, Hon. Trey Gowdy [chairman of the committee] presiding.

Present: Representatives Gowdy, Jordan, DesJarlais, Massie, Meadows, Ross, Walker, Blum, Hice, Russell, Grothman, Comer, Gianforte, Norton, Clay, Lynch, Connolly, Watson Coleman, Plaskett, Demings, Krishnamoorthi, Welch, and DeSaulnier.

Chairman GOWDY. The Committee on Oversight and Government Reform will come to order.

Without objection, the chair is authorized to declare a recess at any time. Before Mr. Connolly and I give our opening statements, I do want to thank everyone, our guests, our panelists, those in the audience, the members and staff, and everyone, for how accommodating you were this morning. We had an unforeseen contingency that arose in our normal hearing room. So thank you for being so understanding.

Over the past 2 decades, illicit drug use has emerged as a public health and safety crisis, with overdoses becoming the leading cause of injury or death in the United States. Opioids, specifically heroin and prescription pain relievers, are the cause of most overdose deaths in the United States, with the death rate more than doubling since the year 2000.

In South Carolina, which is where I'm from, at least 95 people died from heroin in 2015, which is almost twice as many as the previous year. And more than 560 died from the abuse of prescription opioids over the same period of time. The epidemic is growing and lives are at stake, literally. It is imperative our Nation maintain a strong coordinated effort across the Federal Government to combat drug abuse from design, manufacturing, distribution, prescription, and consumption.

In 1988, Congress established the Office of National Drug Control Policy as part of the Anti-Drug Abuse Act to coordinate drug programs across the Federal Government, advise the administration on national and international drug control policies, and create and oversee the National Drug Control Budget. ONDCP is uniquely equipped to address what role the Federal Government can play in

determining what kinds of clinical, social, welfare, and economic programs could impact and reverse drug abuse problems in our country.

ONDCP was last authorized in 2006. The authorization lapsed in 2010, but the office has continued to receive appropriations each year. In December 2015, this committee held a hearing to discuss various proposals for reauthorization. We heard from the then director who testified combatting the abuse of prescription drugs was a top priority for the agency. However, since then, ONDCP has failed to produce a formal National Drug Control Strategy and a National Drug Control Budget, which is supposed to be released no later than February 1 each year.

In the meantime, deaths due to opioid overdoses have only increased in the U.S. in 2016. No office is perfect. God knows Congress certainly is not, but it is our responsibility, nonetheless, to see that deadlines are met, particularly statutory deadlines, resources are well spent, and the leadership that can be provided nationally is being provided. There is a prevention aspect, a treatment aspect, an education aspect, an enforcement aspect, a punishment aspect, and an oversight aspect, the Federal Government has long occupied a space as it relates to both the illicit use of legal drugs and the use of illegal drugs.

Today, we will have an opportunity to consider options for reauthorizing ONDCP and learn about how this agency can work for the goal of reducing and ultimately eliminating our Nation's opioid crisis. We will also examine how ONDCP can help mitigate the significant harm communities across America have felt as a result of our Nation's opioid crisis.

There are many areas worthy of exploration today, and we thank all of our witnesses for appearing before the committee. We look forward to your testimony as we consider next steps for reauthorization.

And with that, I would recognize my friend from Virginia.

Mr. CONNOLLY. I thank the chair, and I want to thank him personally for having this hearing. I also want to thank him personally for his absolute willingness to accommodate our witnesses and to hear the case for why we felt, especially Mr. Flattery being added, really would add a dimension of a personal story that Mr. Flattery has courageously been willing to share. And I just thank my friend from South Carolina.

And this is an area where we can find common ground, where bipartisan cooperation must occur, and I know the chairman is committed to doing it, as am I.

We're in the midst of a national public health emergency. The opioid epidemic has taken thousands, tens of thousands of lives across America, and unfortunately, shows no signs of ending. Every day, every day, 91 Americans die from an opioid overdose. This epidemic doesn't care where you live or what political party you belong to. The crisis has touched every corner of our Nation.

Where I come from, Northern Virginia, is no exception. Fairfax County, which I chaired for 5 years, reported more than 100 drug-related deaths last year. Prince William County, the other county I represent, reported 52. These are astronomical numbers by our normal standards.

Today, we have on our panel Don Flattery, a father from Fairfax County, and his wife has joined him here today too. His son, their son, Kevin, tragically lost his life to opioid overdose 2 years ago—3 years ago. Kevin was a graduate of the University of Virginia. He aspired to a career in film making, but he became addicted to OxyContin because of a medical prescription and a particular medical condition, and he died at the age of 26.

Mr. Flattery has been an outspoken advocate for the need to address this crisis, and we all welcome his testimony here today.

Every day, people across the country die from drug addiction. Families are torn apart. Americans are suffering. The crisis cannot wait. As Members of Congress, we've got to do everything we can to assist and ameliorate and reverse this crisis. Unfortunately, we're not sensing that same sense of urgency from the administration. On the campaign trail, President Trump repeatedly promised action. He said, and I quote: We're going to help. The people that are seriously addicted, we're going to help those people, unquote.

But we're 6 months into the administration and the President has still not appointed a drug czar to lead the Office of National Drug Control Policy, nor has the administration produced a National Drug Control Strategy. Instead, what the President has done is propose cutting the programs that are already working. His proposed budget would cut $370 million to the Substance Abuse and Mental Health Services Administration, which provides grants for opioid overdose drugs, mental health, and prevention programs. In the midst of a national emergency, we cannot accept that.

The President's efforts to repeal the Affordable Care Act also would have devastating effects on Americans suffering from drug addiction. The latest effort to repeal the ACA would take health insurance away from 2.8 million people with substance abuse disorders. Let me repeat that: 2.8 million. Congress must not let that happen. Additionally, repeal of the Affordable Care Act could also make it difficult for individuals with substance use disorders to find the help they need. Legislation repealing the bill would allow States to waive the ACA requirement that mental health and substance abuse treatment are part of the essential health services. This would leave many of those seeking help without insurance coverage on those areas for the very treatment they desperately need.

We're here today to discuss reauthorization of the Office of National Drug Control Policy. This office plays a critical role in coordinating the Federal response to our Nation's drug epidemic. The office manages a budget of more than $370 million and coordinates the related activities of 16 different Federal departments and agencies.

ONDCP also administers two Federal grant programs. Communities in my district, for example, have been fortunate to receive assistance for what's called the High Intensity Drug Trafficking Area Program, which provides grants to localities and States and Tribal areas to counter drug trafficking activities.

In 2010, we saw a shift to emphasizing public health based services within the National Drug Control Strategy. I look forward to hearing more about the importance of a comprehensive approach to this challenge. Prevention and treatment are important tools work-

ing together, as the chairman suggested, in how we approach this. What is also important is ensuring that any national drug control strategy is based on empirical evidence and one that prioritizes results over prior beliefs or ideology. Evidence should always guide public policy, particularly when addressing matters of public health and safety.

We've witnessed the perils of failing to follow that prescription in our marijuana policies, and cannot afford to repeat just costly mistakes. This committee held a number of hearings on that topic in the last several years, and each time I noted we have no empirical evidence that justifies marijuana as classified a Schedule I drug. In fact, the U.S. National Institute on Drug Abuse, NIDA, which for years was the sole Federal entity that controlled access to the Federal Government's lone research supplier of marijuana, was unwilling to fund or conduct any Federal research into the question of whether marijuana might have positive benefits.

This lack of empirical evidence to support our policy has lead us down a dark path, wherein our national drug policy has provided cover for arresting all too many minority Americans for nonviolent offenses at rates up to eight times those of White Americans, and filling our prisons beyond maximum capacity, scarring them and their families, often for life. We've got to rethink that approach, and it's got to be empirical based.

I want to thank our panelists for being here today, Mr. Chairman, for their contributions to the Office of National Drug Control Policy and their personal contributions to this dialogue. And I want to reiterate my commitment to cooperate with you, Mr. Chairman, and our mutual staffs to make sure that we are aggressively addressing this critical issue that is now afflicting our country.

Thank you so much. I yield back.

Chairman GOWDY. The gentleman from Virginia yields back.

We'll hold the record open for 5 legislative days for any members who would like to submit a written statement.

I'm going to recognize our witnesses. I will recognize you from my right to left and then introduce you that way and then recognize you for your opening statements. I would tell all the witnesses, your opening statement is part of the record. I am sure that my colleagues have read it. So to the extent you can, keep your opening statement within 5 minutes so the members can have an active dialogue with you.

Our first witness is Mr. Richard Baum, Acting Director of the Office of National Drug Control Policy. Next, we have Ms. Diana Maurer, Director of Justice and Law Enforcement Issues at the Government Accountability Office. We have Dr. Humphreys, who is a professor of psychiatry and behavioral sciences at Stanford University. And Mr. Don Flattery, who is an addiction policy advocate and a parent who has been impacted by today's subject matter.

We want to welcome all of you, and thank you for being here. Pursuant to committee rules, all witnesses are to be sworn in before they testify. So I would ask you to please rise and lift your right hand.

Do you solemnly swear the testimony you're about to give is to be the truth, the whole truth, and nothing but the truth, so help you God?

May the record reflect all the witnesses answered in the affirmative. You may sit down.

With that, we will recognize Director Baum.

WITNESS STATEMENTS

STATEMENT OF RICHARD BAUM

Mr. BAUM. Chairman Gowdy, Ranking Member Connolly, and members of the committee, thank you for inviting me to appear before you today to discuss the activities of the Office of National Drug Control Policy.

Mr. CONNOLLY. Is your mic on?

Mr. BAUM. How's that? Is that better?

Mr. CONNOLLY. I think it just might be old age on our behalf.

Mr. BAUM. Do I need to get real close in there?

Mr. CONNOLLY. That's good.

Chairman GOWDY. That's good.

Mr. BAUM. All right. I'm going to start over. Can you restart the clock for me?

Chairman Gowdy, Ranking Member Connolly, and members of the committee, thank you for inviting me to appear before you today to discuss the activities of the Office of National Drug Control Policy. It's a tremendous honor for me to be here and to serve as acting director of the agency where I've worked for two decades.

At ONDCP, we have a dedicated team of policy experts who are working to address the opioid crisis and the full range of drug threats our country faces. Having the strong support of the President, his administration, and Congress, particularly, this committee, means a great deal to us.

Given the state of this crisis, reauthorizing the office charged with responding to it is more important than ever. Thank you for taking this on. We're grateful.

As you are all aware, we're in the midst of the worst drug epidemic in U.S. history. In 2015, we lost more than 52,000 people to drug overdose, including more than 33,000 to overdoses involving opioids. The opioid epidemic began with the overprescribing of prescription drugs and has evolved to include heroin, and increasingly, illicit fentanyl.

In my time as acting director, I've met with parents who have lost children, visited communities hit hard by this epidemic. When I was in Johnstown, Pennsylvania, students at the University of Pittsburgh, Johnstown, had just found out that a star on the wrestling team had died of an overdose involving fentanyl. It's heartbreaking to hear the stories of lost lives, and we know these are stories you've heard in your districts and all over the country.

Most lethal drugs are not made in the U.S., and ONDCP works with Federal and international partners to improve international drug control and dismantle the organizations that traffic these deadly drugs into our communities. Beyond opioids, we also face a rapidly growing threat from cocaine, as well as serious threats from methamphetamine, synthetic drugs, and marijuana. I look forward to discussing these specific drug threats in more detail in the Q&A.

ONDCP serves as the lead drug control agency and advisory to the President on drug issues. Our activities include policy develop-

ment, coordination, and drug budget oversight, as well as targeted grant funding. Our position within the White House provides a platform to build support for proven strategies to address quickly evolving drug threats.

ONDCP strongly supports a comprehensive policy approach to address all aspects of the drug problem, supply and demand. Reducing the drug supply is critical to our overall efforts. The U.S. must use every tool available, including working with partner nations on drug crop eradication, land and sea interdiction, and destroying the criminal networks which bring these substances into our country and smuggle illicit proceeds out. Domestic law enforcement, including State and local agencies, play a critical role in reducing drug availability and building cases against trafficking groups.

ONDCP also plays a critical role in promoting the science of addiction and evidence-based treatment and breaking the stigma surrounding substance abuse so people will be more likely to seek treatment and to achieve and maintain lifetime recovery. Prevention is a vital component of addressing drug abuse in this country. I've, therefore, made it a priority to reinvigorate a national prevention effort to engage youth in schools and online. This is a critical component for preventing drug use from beginning in the first place.

ONDCP is also focused on supporting ways for the criminal justice system to better address addiction within its populations. For many people, engagement with the law is the first opportunity to access treatment services. Whether through pretrial or prearrest diversion to treatment via drug courts or through treatment within correctional settings, it's better for all of us that those who need treatment receive it.

As you know, ONDCP writes the President's National Drug Control Strategy, which provides a comprehensive and science-based national approach to reducing the use of illicit drugs and their consequences. This strategy is guided by input from Members of Congress and other stakeholders. The Trump administration envisions an action-oriented strategy, and our efforts to prepare the President's inaugural strategy are underway. And I'm happy to get more into this in the Q&A.

One of our greatest strengths is the ability to coordinate drug control activities across the Federal Government and work directly with State, local, Tribal, and international partners to further the administration's drug policy goals. We use our budget oversight authority to prevent duplication and make sure Federal dollars are well spent. We work to lift up innovative programs at the State and local level, such as the Police Assisted Addiction and Recovery Initiative, or PAARI, where police work with public health to connect people with addiction to drug—with treatment for drug addiction.

And we coordinate the response to specific drug threats. Our National Heroin Coordination Group and national cocaine group were designed to make us more nimble and approve drug-specific coordination across government, such as developing safe handling instructions for fentanyl so first responders don't experience over-

dose, and prioritizing efforts to take down dark web marketplaces on the internet for drugs like fentanyl.

On July 5, the Department of Justice took down AlphaBay, a primary source of fentanyl. As you're well aware, ONDCP runs two grant programs that work to address the national problem. The HIDTA program facilitates coordination between local law enforcement, State, and Federal officials, and approves antitrafficking operations in each of the 28 HIDTAs. The DFC program provides grants to nearly 700 community-based antidrug coalitions across the country.

Before I close, I'd like to acknowledge and thank the Government Accounting Office. We have been through numerous engagements with GAO, and I've found that their recommendations have been extremely helpful to us in our work.

We look forward to working with the committee on a reauthorization measure that aligns with the administration's priorities and provides the framework for ONDCP to best address the serious crisis the country faces on drugs.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Mr. Baum follows:]

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

Hearing on the Reauthorization of the Office of National Drug Control Policy

Committee on Oversight and Government Reform
United States House of Representatives

Wednesday, July 26, 2017
10:00 a.m.
2154 Rayburn House Office Building

Written Statement of:
Richard J. Baum
Acting Director of National Drug Control Policy

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 over[1] 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]

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[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

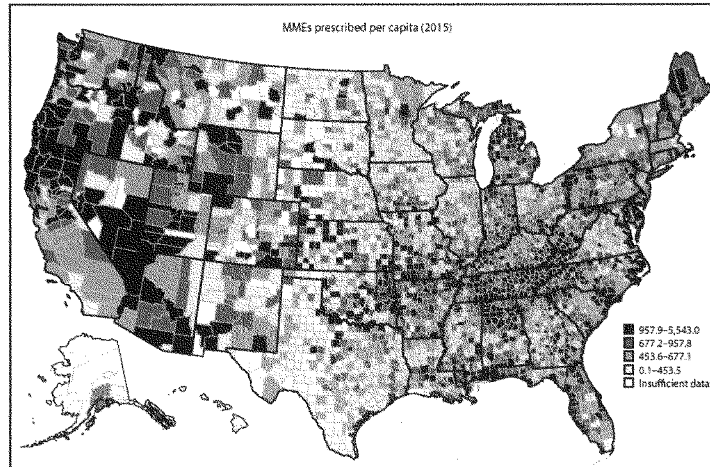
[11] SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,. Table 5.22A Substances for Which Last or Current Treatment Was Received among Persons Who Received Substance Use Treatment in Past Year, by Age Group: Numbers in Thousands, 2014 and 2015

[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 2015[15]



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.

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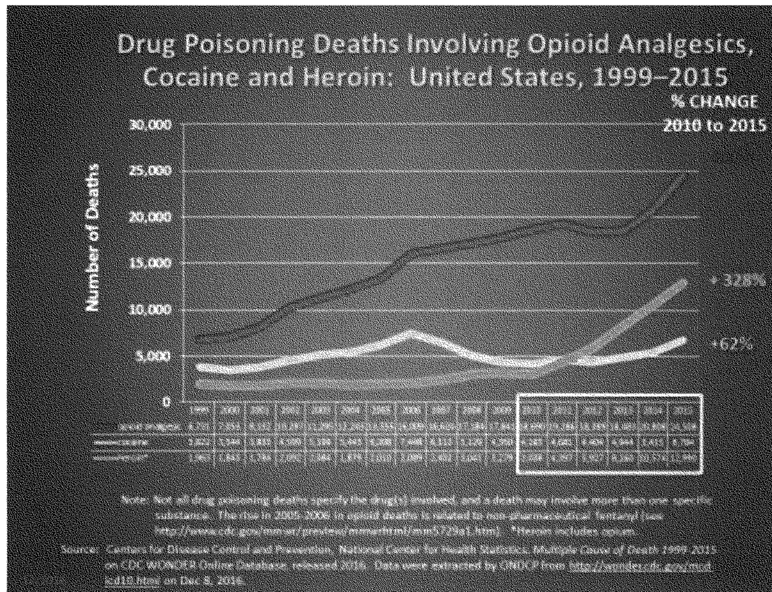
[15] Ibid

[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.

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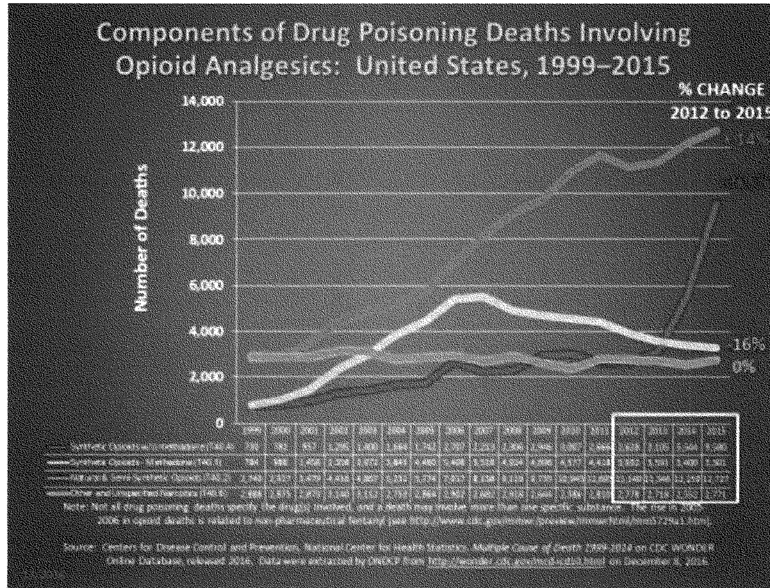
[17] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database, released 2016. Data were extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on Dec 8, 2016.
[18] Ibid
[19] Ibid
[20] Centers for Disease Control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

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[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.

Chairman GOWDY. Thank you, Director Baum.
Ms. Maurer.

STATEMENT OF DIANA MAURER

Ms. MAURER. Good morning, Chairman Gowdy, Ranking Member Connolly, and other members and staff. I'm pleased to be here today to discuss GAO's recent work on Federal efforts to address illicit drug use.

Combatting drug trafficking, drug abuse, and the associated impacts on public health and public safety is costly. The current administration has requested nearly $28 billion for a wide variety of activities involving several Federal agencies. It's a truly multifaceted effort with very different missions in public health, law enforcement, intelligence, education, corrections, and diplomacy, and it needs to be.

The problems from illicit drug use in the United States are complex, widespread, and deep-seated. And if there's one thing we've learned over the past several decades, there are no quick or easy fixes. But more significant than the cost and complexity of Federal efforts is the very human, very tragic, and increasingly deadly toll of illicit drugs.

According to the CDC, there were over 52,000 deaths from drug overdoses in 2015. That's up more than 40 percent since 2009. It's difficult to grasp numbers like that. 52,000 death in a year means 144 Americans die every day. That's more every 2 days than in all the terrorist attacks in this country since 9/11. There's another way to think about it. The Vietnam Veterans Memorial here in Washington, D.C. has over 58,000 names on it. So one way to visualize the current human impact of illicit drugs is to picture building a memorial of similar size every single year.

Given these bleak facts, it's vital that taxpayer dollars to address this problem are well spent, that we're making progress, and that the various agencies are well-coordinated. Those are goals to keep in mind as you consider reauthorization. It's important for ONDCP and the various agencies to have a clear strategy to guide them, goals and measures to know whether they're making progress, and seamless coordination and collaboration.

And over the years, ONDCP, to its credit, has focused a great deal of time and attention developing strategies and using performance measures to assess the progress of Federal drug control efforts. The administration is currently updating the National Drug Control Strategy. Since that remains a work in progress, my comments today are based on goals and measures from previous strategies.

In 2010, ONDCP issued a series of goals with specific outcomes the Federal Government hoped to achieve by the end of 2015. And as we have previously reported and testified, ONDCP's goals provided a dashboard with meaningful indicators of progress and clear goals. The Federal Government achieved none of the seven overall goals established in 2010. Now, in some key areas, the trend line moved in the opposite direction; things got worse. For example, the number of drug-related deaths increased over 41 percent, rather than decreasing 15 percent as planned. The prevalence of drug use

by young adults increased rather than decreased, largely due to increased marijuana use.

But there is also important progress in some key areas. There have been substantial reductions in the use of alcohol and tobacco by eighth graders. And the prevalence of drug use by teenagers has also dropped, not enough to meet the goals set in 2010, but certainly an encouraging sign. And preventing drug use is a key part of the overall Federal effort.

Last year, the comptroller general convened a diverse group of healthcare, law enforcement, and education experts to discuss, among other things, high priority areas for future prevention efforts. They identified several options, including increasing the use of prevention programs that research has shown to be effective; working to change perceptions of substance abuse; emphasizing that a substance use disorder is a disease that can be treated; reducing the number of prescriptions issued for opioids; supporting community coalitions that include the healthcare, education, and law enforcement sectors; and improving Federal data on drug use.

Mr. Chairman, as Congress considers these and other options while debating ONDCP's reauthorization, it's worth reflecting on the deeply ingrained nature of illicit drug use in this country. It's an extremely complex problem that involves millions of people, billions of dollars, and thousands of communities. GAO stands ready to help Congress assess how well ONDCP and the other Federal agencies are doing to reduce the impact of illicit drug use.

Thank you for the opportunity to testify this morning, and I look forward to your questions.

[Prepared statement of Ms. Maurer follows:]

United States Government Accountability Office

Testimony
Before the Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
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DRUG CONTROL POLICY

Information on Status of Federal Efforts and Key Issues for Preventing Illicit Drug Use

Statement of Diana Maurer,
Director, Homeland Security and Justice Issues

GAO-17-766T

GAO Highlights

Highlights of GAO-17-766T, a testimony before the Committee on Oversight and Government Reform, House of Representatives

July 26, 2017

DRUG CONTROL POLICY

Information on Status of Federal Efforts and Key Issues for Preventing Illicit Drug Use

Why GAO Did This Study

According to the National Institute on Drug Abuse, in 2015, the most recent year for which national data are available, over 52,000 Americans died from drug overdoses, or approximately 144 people every day. Policymakers, criminal justice officials, health care providers, and the public at large are turning with renewed attention to the drug epidemic and its impact on our nation. To help reduce illicit drug use and its consequences, ONDCP oversees and coordinates the implementation of national drug control policy across the federal government.

This statement addresses: (1) the federal government's progress in achieving Strategy goals, (2) results from a Comptroller General's Forum on preventing illicit drug use, and (3) the findings of GAO's recent review of ONDCP's DFC Support program.

This statement is based on GAO's prior work issued from May 2016 through February 2017, with selected status updates as of July 2017, and updates from ONDCP's National Drug Control Budget Funding Highlight reports issued from fiscal year 2016 to fiscal year 2018. For the updates, GAO used publically available data sources that ONDCP uses to assess its progress on Strategy goals, and interviewed ONDCP officials.

View GAO-17-766T. For more information, contact Diana Maurer at (202) 512-8777 or maurerd@gao.gov.

What GAO Found

The federal government has made mixed progress toward achieving the goals articulated in the 2010 National Drug Control Strategy (Strategy). In the Strategy, the Office of National Drug Control Policy (ONDCP) established seven goals related to reducing illicit drug use and its consequences by 2015. In many instances, the data used to assess progress in 2015 have only recently become available. GAO's review of this updated data indicates that, as of July 2017, the federal government made moderate progress toward achieving two goals, limited progress on two goals, and no progress on the other three goals. However, none of the overall goals in the Strategy were fully achieved. For example, progress had not been made on the goal to reduce drug-induced deaths by 15 percent. Drug-induced deaths instead increased from 2009 to 2015 by 41.5 percent. Although progress was made reducing the 30-day prevalence of drug use among 12- to 17-year-olds from the 10.1 percent reported in 2009, the goal of reducing prevalence to 8.6 percent by 2015 was not achieved. According to ONDCP, as of July 2017, work is currently underway to develop a new strategy.

In June 2016, GAO convened a diverse panel of experts, including from ONDCP to advance the national dialogue on preventing illicit drug use. The panel focused on (1) common factors related to illicit drug use; (2) strategies in the education, health care, and law enforcement sectors to prevent illicit drug use; and (3) high priority areas for future action to prevent illicit drug use. According to forum participants, illicit drug use typically occurs for the first time in adolescence, involves marijuana, and increasingly, legal prescriptions for opioid-based pain relievers. Forum participants also discussed strategies available in the education, health care, and law enforcement sectors for preventing illicit drug use. For example, forum participants championed the use of school- or-community-based prevention programs that research has shown to be successful in preventing illicit drug use and other behaviors. They also identified several high priority areas for future actions to prevent illicit drug use, including: supporting community coalitions, consolidating federal funding streams for prevention programs, and reducing the number of opioid prescriptions.

In February 2017, GAO issued a report on the Drug-Free Communities Support Program (DFC)—a program that ONDCP and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly manage. This program aims to support drug abuse prevention efforts that engage schools, law enforcement, and other sectors of a community to target reductions in the use of alcohol, tobacco, marijuana, and the illicit use of prescription drugs. GAO reported that ONDCP and SAMHSA had strengthened their joint management of the program by employing leading collaboration practices; however, the agencies could enhance DFC grantee compliance and performance monitoring. For example, SAMHSA did not consistently confirm grantees had completed plans to achieve long-term goals after exiting the program. GAO recommended that SAMHSA develop an action plan to strengthen DFC grant monitoring and ensure it sends complete and accurate information to ONDCP. SAMHSA concurred with GAO's recommendations and reported in April 2017 that its actions to address them should be completed by this fall.

Chairman Gowdy, Ranking Member Cummings, and Members of the Committee:

I am pleased to be here today to discuss GAO's recent work related to the Office of National Drug Control Policy (ONDCP). Though drug abuse in our nation is not a new phenomenon, the scale and impact of illicit drug use in this country has reached new heights. Policy makers, criminal justice officials, health care providers, and the public at large are turning with renewed attention to the drug epidemic and its impact on our nation. Deaths from drug overdoses have risen steadily over the past two decades and are the leading cause of death due to injuries in the United States. In fact, according to the Centers for Disease Control and Prevention (CDC), drug overdose deaths surpass the annual number of traffic crash fatalities, as well as deaths due to firearms, suicide, and homicide. In 2015, the most recent year for which national data are available from the National Institute on Drug Abuse (NIDA), over 52,000 Americans died from drug overdoses, or approximately 144 people every day.

ONDCP is responsible for, among other things, overseeing and coordinating the implementation of national drug control policy across the federal government to address illicit drug use.[1] In this role, the Director of ONDCP is required annually to develop a National Drug Control Strategy (the Strategy), which is to set forth a comprehensive plan to reduce illicit drug use through programs intended to prevent or treat drug use or reduce the availability of illegal drugs.[2] According to ONDCP, work is currently underway to develop a new Strategy. ONDCP is also responsible for developing a National Drug Control Program Budget proposal for implementing the Strategy.[3] For fiscal year (FY) 2018, a total of $27.8 billion was requested to support federal drug control efforts. As I

[1]Illicit drug use includes the use of marijuana (including hashish), cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription drugs, such as pain relievers and sedatives.

[2]For the purposes of this statement we refer to the National Drug Control Strategy as 'the Strategy' mirroring the reference commonly used by ONDCP.

[3]21 U.S.C. §§ 1703(b)-(c), 1705(a).

will detail in my statement, this represents an increase of about $280 million over the annualized Continuing Resolution (CR) level in FY 2017.[4]

Today, I will discuss (1) the federal government's progress achieving the National Drug Control strategy goals, (2) results of a Comptroller General (CG) Forum on preventing illicit drug use, and (3) the findings of our recent review of ONDCP's Drug-Free Communities (DFC) Support program.

This statement is based on our prior work issued from May 2016 through February 2017 with selected updates as of July 2017.[5] In performing the work for our May 2016 testimony, we analyzed available data on progress toward achieving Strategy goals, as well as documents related to ONDCP's monitoring mechanisms. For this statement we updated the information and data where appropriate from publically available data sources and ONDCP's Fiscal Year 2016 through Fiscal Year 2018 National Drug Control Budget Funding Highlights reports, and interviews with ONDCP officials. For our November 2016 CG Forum, we convened and moderated a panel of education, health care, and law enforcement officials and summarized the viewpoints shared on common factors related to illicit drug use; strategies in the education, health care, and law enforcement sectors to prevent illicit drug use; and high priority areas for future action to prevent illicit drug use. For our February 2017 report on the DFC, we analyzed agency policies, interviewed agency officials, analyzed coordination efforts against relevant key practices GAO identified previously, reviewed files obtained from a non-generalizable random sample of grant recipients and interviewed a random subset of these grantees. More detail on our scope and methodologies can be found in each of these respective products.

[4]A continuing resolution (CR) is an appropriation act that provides budget authority for federal agencies, specific activities, or both to continue in operation when Congress and the President have not completed action on the regular appropriation acts by the beginning of the fiscal year.

[5]See GAO, *Office of National Drug Control Policy: Progress Toward Some National Drug Control Strategy Goals, but None Have Been Fully Achieved*, GAO-16-660T (Washington, D.C.: May 17, 2016), GAO, *Highlights of a Forum: Preventing Illicit Drug Use*, GAO-17-146SP (Washington, D.C.: Nov. 14, 2016), and GAO, *Drug-Free Communities Support Program: Agencies Have Strengthened Collaboration but Could Enhance Grantee Compliance and Performance Monitoring*, GAO-17-120 (Washington, D.C.: Feb. 7, 2017).

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

ONDCP was established by the Anti-Drug Abuse Act of 1988 to, among other things, enhance national drug control planning and coordination and represent the drug policies of the executive branch before Congress.[6] In this role, the office is responsible for (1) developing a national drug control policy, (2) developing and applying specific goals and performance measurements to evaluate the effectiveness of national drug control policy and National Drug Control Program agencies' programs,[7] (3) overseeing and coordinating the implementation of the national drug control policy, and (4) assessing and certifying the adequacy of the budget for National Drug Control Programs.[8]

ONDCP is required annually to develop the National Drug Control Strategy, which sets forth a plan to reduce illicit drug use through prevention, treatment, and law enforcement programs, and to develop a National Drug Control Program Budget for implementing the strategy. National Drug Control Program agencies follow a detailed process in developing their annual budget submissions for inclusion in the National Drug Control Program Budget, which provides information on the funding that the executive branch requested for drug control to implement the strategy.[9] Agencies submit to ONDCP the portion of their annual budget

[6]Pub. L. No. 100-690, 102 Stat. 4181 (1988).

[7]In addition to ONDCP, these agencies are: the Departments of Agriculture, Defense, Education, Health and Human Services, Homeland Security, Housing and Urban Development, the Interior, Justice, Labor, State, Transportation, Treasury, and Veterans Affairs, as well as the Court Services and Offender Supervision Agency for the District of Columbia; and the Federal Judiciary.

[8]21 U.S.C. § 1702(a).

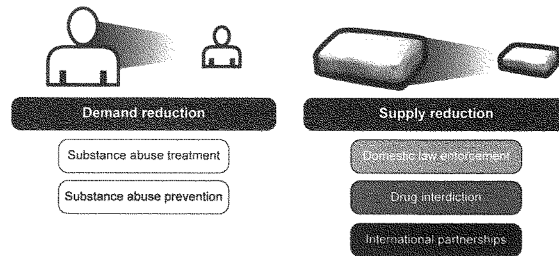
[9]21 U.S.C. § 1703(c). Under 21 U.S.C. § 1701(7), the term "National Drug Control Program agency" means any agency that is responsible for implementing any aspect of the National Drug Control Strategy, including any agency that receives federal funds to implement any aspect of the National Drug Control Strategy, subject to certain exceptions regarding intelligence agencies.

requests dedicated to drug control, which they prepare as part of their overall budget submission to the Office of Management and Budget for inclusion in the President's annual budget request. ONDCP reviews the budget requests of the drug control agencies to determine if the agencies have acceptable methodologies for estimating their drug control budgets, and includes those that do in the Drug Control Budget.[10] In FY 2016, the budget contained 38 federal agencies or programs.

There are five priorities for which resources are requested across agencies: substance abuse prevention and substance abuse treatment (which are considered demand-reduction areas), and domestic law enforcement, drug interdiction, and international partnerships (which are considered supply-reduction areas) as shown in figure 1. ONDCP manages and oversees two primary program accounts: the High Intensity Drug Trafficking Areas (HIDTA) Program and the Other Federal Drug Control Programs, such as the DFC Support Program. ONDCP previously managed the National Youth Anti-Drug Media Campaign which last received appropriations in fiscal year 2011. Also, from fiscal year 1991 to fiscal year 2011, ONDCP managed the Counterdrug Technology Assessment Center (CTAC).

[10] An acceptable methodology relies on availability of empirical data at the agencies for estimating their drug control budgets. These data include determining which portion of an agency's funding is for drug control programs or activities versus non-drug control programs. See GAO, *Office of National Drug Control Policy: Agencies View the Budget Process as Useful for Identifying Priorities, but Challenges Exist*, GAO-11-261R (Washington, D.C.: May 2, 2011). Agencies may administer programs that include drug abuse prevention and treatment activities but do not meet ONDCP's standards for having an acceptable budget estimation methodology. Such programs are not represented in the Drug Control Budget.

Figure 1: Federal Drug Control Program Priority Areas

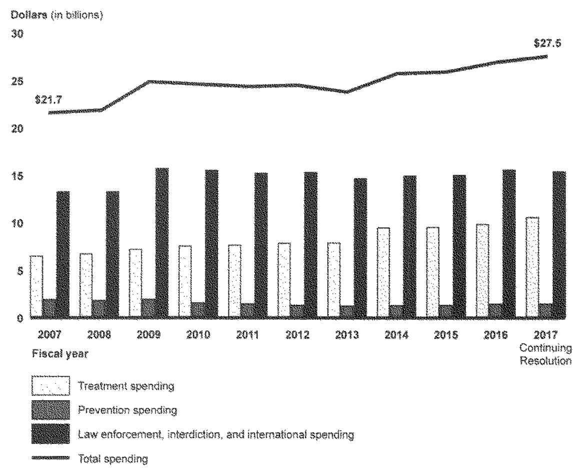


Source: GAO. | GAO-17-766T

According to ONDCP, federal drug control spending increased from $21.7 billion in FY 2007 to the approximately $27.5 billion that was allocated for drug control programs in FY 2017 as shown in figure 2.[11] Spending on supply reduction programs, such as domestic law enforcement, interdiction, and international programs increased 16 percent from $13.3 billion in FY 2007 to $15.4 billion in FY 2017. However, federal spending for demand programs—treatment and prevention— increased at a higher rate from FY 2007 through FY 2017. Spending in these two programs increased 44 percent from $8.4 billion in FY 2007 to $12.1 billion in FY 2017. As a result, the proportion of funds spent on demand programs increased from 39 percent of total spending in FY 2007 to 44 percent in FY 2017.

[11] The fiscal year 2018 National Drug Control Budget Funding Highlights describes fiscal year 2017 allocations. ONDCP refers to these funds as "annualized Continuing Resolution levels" in the National Drug Control Budget, while we use the term allocated funding. All FY 2017 funding is considered allocated funding for purposes of this statement. Funds allocated at the beginning of a fiscal year may not reflect actual agency spending during the course of the fiscal year. For example, appropriations acts may allow agencies to reallocate unobligated funds from one program to another, or actual spending for mandatory funding programs such as Medicare and Medicaid may differ from projected spending levels.

Figure 2: Federal Drug Control Spending for Fiscal Years 2007 through 2017



Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 through 2018. | GAO-17-766T

According to ONDCP's National Drug Control Budget Fiscal Year 2018 Highlights, the proposed budget supports $1.3 billion in investments authorized by the Comprehensive Addiction and Recovery Act (CARA), the 21st Century Cures Act, and other opioid-specific programs to help address the opioid epidemic, including funding prevention and treatment efforts.[12] Allocated funding for treatment increased in FY 2017 to approximately $10.6 billion, a 7.5 percent increase over FY 2016. Funding for prevention increased slightly in FY 2017 to about $1.5 billion, a 1.4 percent increase from FY 2016.

[12]ONDCP, *National Drug Control Budget Fiscal Year 2018 Funding Highlights*, (Washington, D.C.: May 2017)

According to its FY 2018 Budget Highlights document, ONDCP considers three main functions to address the drug supply: Domestic Law Enforcement, Interdiction, and International. For Domestic Law Enforcement, ONDCP noted that federal, state, local, and tribal law enforcement agencies play a key role in the Administration's approach to reduce drug use and its associated consequences. ONDCP also stated that interagency drug task forces, such as the HIDTA program, are critical to leveraging limited resources among agencies. Allocated funding for domestic law enforcement in FY 2017 is approximately $9.3 billion, which is similar to its FY 2016 spending level.

According to ONDCP, the United States continues to face a serious challenge from the large-scale smuggling of drugs from abroad which are distributed to every region in the nation. Interdiction funds support collaborative activities between federal law enforcement agencies, the military, the intelligence community, and international allies to interdict or disrupt shipments of illegal drugs, their precursors, and their illicit proceeds. Allocated funding in support of Interdiction for FY 2017 is approximately $4.6 billion, a decrease of 3.5 percent from FY 2016.

International functions place focus on collaborative efforts between the U.S. government and its international partners around the globe. According to ONDCP, illicit drug production and trafficking generate huge profits and are responsible for the establishment of criminal networks that are powerful, corrosive forces that destroy the lives of individuals, tear at the social fabric, and weaken the rule of law in affected countries. In FY 2017, approximately $1.5 billion was allocated to international functions, which is similar to its FY 2016 spending level.

The Federal Government Has Made Mixed Progress But Has Not Fully Achieved the Overall 2010 Strategy Goals

As we previously have stated, the 2010 National Drug Control Strategy was the inaugural strategy guiding drug policy under the previous Administration. According to ONDCP officials, it sought a comprehensive approach to drug policy, including an emphasis on drug abuse prevention and treatment efforts and the use of evidence-based practices—approaches to prevention or treatments that are based in theory and have undergone scientific evaluation. ONDCP established two overarching policy goals in the 2010 Strategy for (1) curtailing illicit drug consumption and (2) improving public health by reducing the consequences of drug abuse, and seven overall sub goals under them that delineate specific quantitative outcomes to be achieved by 2015, such as reducing drug-induced deaths by 15 percent. To support the achievement of these two policy goals and seven sub goals (collectively referred to as overall

goals), the Strategy included seven strategic objectives and multiple action items under each objective, with lead and participating agencies designated for each action item. Strategy objectives include, for example, "Strengthen Efforts to Prevent Drug Use in Communities" and "Disrupt Domestic Drug Trafficking and Production." Subsequent annual Strategies provided updates on the implementation of action items, included new action items intended to help address emerging drug-related problems, and highlighted initiatives and efforts that support the Strategy's objectives.

In March 2013, we reported that ONDCP and the federal agencies lacked progress on achieving the Strategy goals and were in the process of implementing a new mechanism to monitor progress.[13] As we reported in May 2016, ONDCP and the federal agencies had made moderate progress toward achieving one goal, limited progress on three goals, and no demonstrated progress on the remaining three goals.[14] For example, we reported that the rate of drug use for young adults aged 18 to 25 had increased since 2009, moving in the opposite direction of the goal. However, we also reported that HIV infections attributable to drug use, one of the strategy's sub-measures, had decreased from 2009 to 2014 and had exceeded the strategy's established target. In many instances, the data used to assess progress, while the most up to date at the time, were several years old. Based on the most recent data available, although some of the sub-measures, such as decreasing tobacco use by eighth graders, were achieved, none of the seven overall goals in the Strategy have been fully achieved as of July 2017. Table 1 shows the 2010 Strategy goals and progress toward meeting them as of July 2017.

[13]See GAO: *Office of National Drug Control Policy: Office Could Better Identify Opportunities to Increase Program Coordination;* GAO-13-333 (Washington, D.C.: March 26, 2013).

[14]GAO-16-660T. Three of the Strategy's goals have multiple sub-measures. Limited progress indicates that progress has been made toward goals on at least one of these measures but not all.

Table 1: 2010 National Drug Control Strategy Goals and Progress toward Meeting Them, as of July 2017

2010 Strategy goals	2009 (baseline)	2015 (goal)	Progress as of most recently available data[a]
Curtail illicit drug consumption in America			
1. Decrease the 30-day prevalence of drug use among 12- to 17-year- olds by 15 percent[b]	10.1 percent	8.6 percent	8.8 percent (2015)
2. Decrease the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco by 15 percent[c]			
Illicit drugs	19.9 percent	16.9 percent	17.2 percent (2016)
Alcohol	36.6 percent	31.1 percent	22.8 percent (2016)
Tobacco	20.1 percent	17.1 percent	9.8 percent (2016)
3. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10 percent[d]	21.4 percent	19.3 percent	22.3 percent (2015)
4. Reduce the number of chronic drug users by 15 percent[e]			
Cocaine	2.7 million	2.3 million	2.5 million (2010)
Heroin	1.5 million	1.3 million	1.5 million (2010)
Marijuana	16.2 million	13.8 million	17.6 million (2010)
Methamphetamine	1.8 million	1.5 million	1.6 million (2010)
Improve the public health and public safety of the American people by reducing the consequences of drug abuse			
5. Reduce drug-induced deaths by 15 percent	39,147	33,275	55,403 (2015)
6. Reduce drug-related morbidity by 15 percent			
Emergency room visits for drug misuse and abuse[f]	2,070,452	1,759,884	2,462,948 (2011)
HIV infections attributable to drug use	5,799	4,929	3,594 (2015)
7. Reduce the prevalence of drugged driving by 10 percent[g]	16.3 percent (2007)	14.7 percent	20.0 percent (2013)

Source: GAO review of ONDCP's 2015 Performance Reporting System report and data from (1) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH); (2) National Institute on Drug Abuse's Monitoring the Future; (3) What America's Users Spend on Illegal Drugs; (4) Centers for Disease Control and Prevention's (CDC) National Vital Statistics System, (5) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits, (6) CDC's HIV Surveillance Report-Diagnoses of HIV Infection in the United States; and (7) National Highway Traffic Safety Administration's National Roadside Survey. | GAO-17-766T

[a]Year for which the most recent data were available is in parenthesis.

[b]NSDUH is a statistical sample survey and these results from this survey are population estimates. According to the 2015 NSDUH, 7 percent of 12- to 17-year-olds reporting having used marijuana in the past month.

[c]According to the 2016 Monitoring the Future survey, 12.8 percent of eighth graders reported having used marijuana in their lifetimes and 8.9 percent reported having used any illicit drug other than marijuana.

[d]According to the 2015 NSDUH, 19.8 percent of 18- to 25-year-olds reported having used marijuana in the past month.

[e]The data source for this measure is a report entitled *What America's Users Spend on Illegal Drugs*, which is sponsored by ONDCP and prepared by RAND Corporation. As of July 2017, the most recent report had been released in February 2014 and provided data from 2000 through 2010.

[f]According to ONDCP's 2015 Performance Reporting System report, the data source for this measure—the Drug Abuse Warning System—was discontinued by SAMHSA in 2011, and SAMHSA and CDC are currently working to implement a replacement system to provide data on drug-related emergency department visits. SAMHSA's Drug Abuse Warning Network was a statistical sample survey of hospital emergency rooms and the results from this survey were population estimates.

[g]The primary data source for this measure is the National Roadside Survey conducted by the National Highway Traffic Safety Administration. The baseline survey was conducted in 2007. The NSDUH, which also measures the prevalence of drugged driving, serves as a secondary data source to the National Roadside Survey. ONDCP reported that the drugged driving goal was met when 2013 data from the NSDUH source is used.

Federal drug control agencies made mixed progress but did not fully achieve any of the four overall Strategy goals associated with curtailing illicit drug consumption. For example:

- Progress was made on the goal to decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent. The data source for this measure— SAMHSA's National Survey on Drug Use and Health (NSDUH)[15]— indicated that in 2015, 8.8 percent of 12- to 17-year-olds reported having used illicit drugs in the past month.
- Progress was not made on the goal to decrease the 30-day prevalence of drug use among young adults aged 18 to 25 by 10 percent. Specifically, the reported rate of drug use for young adults was 21.4 percent in 2009 and 22.3 percent in 2015, moving in the opposite direction of the goal. Marijuana remained the drug used by the highest percentage of young adults. According to the 2015 NSDUH, 19.8 percent of young adults reported having used marijuana in the past month.[16] The rates of reported marijuana use for this measure increased by 9 percent from 2009 to 2015.

Progress was also mixed on the remaining three overall Strategy goals associated with reducing the consequences of drug use. For example:

- Progress was not made on the goal to reduce drug-induced deaths by 15 percent. According to the CDC's National Vital Statistics System, which collects information on all deaths in the United States, 55,403 deaths were from drug-induced causes in 2015, an increase of 41.5 percent compared to 2009 and 66.5 percent more than the 2015 goal. The CDC's December 30, 2016 Morbidity and Mortality Weekly

[15]NSDUH is a statistical sample survey.

[16] Marijuana includes marijuana and hashish.

Report stated that 52,404 of these deaths were from drug overdoses, the majority of which (63 percent) involved opioids.

- The goal to reduce drug-related morbidity by 15 percent has two sub-measures, and progress had been made on one but not the other. Specifically, HIV infections attributable to drug use decreased by 29 percent from 2010 to 2015, exceeding the established target. However, the number of emergency room visits for substance use disorders increased by 19 percent from 2009 to 2011. The data source for this measure— SAMHSA's Drug Abuse Warning Network[17]—indicated that pharmaceuticals alone were involved in 34 percent of these visits and illicit drugs alone were involved in 27 percent of them.[18] According to the 2013 Drug Abuse Warning Network report, the increase in emergency room visits for drug misuse and abuse from 2009 to 2011 was largely driven by a 38 percent increase in visits involving illicit drugs only.

Themes from a Comptroller General Forum on Preventing Illicit Drug Use

To advance the national dialogue on preventing illicit drug use, including preventing individuals from using illicit drugs for the first time, we convened and moderated a diverse panel of health care, education, and law enforcement experts, including from ONDCP, on June 22, 2016. The panel focused on (1) common factors related to illicit drug use; (2) strategies in the education, health care, and law enforcement sectors to prevent illicit drug use; and (3) high priority areas for future action to prevent illicit drug use, and our November 2016 report[19] summarized the themes from the forum.

Forum participants identified a number of common factors related to illicit drug use. For example, the participants agreed that first time illicit drug use typically starts in adolescence and typically involves marijuana, however, prescription pain relievers are increasingly a pathway to illicit drug use. Other common factors include: a family history of substance abuse, conflict within the family, and the early onset of anxiety disorders or substance use, among others.

[17]SAMHSA's Drug Abuse Warning Network is a statistical sample survey of hospital emergency rooms.

[18] These numbers do not include visits that involved a combination of illicit drugs, pharmaceuticals, and/or alcohol, which accounted for an estimated 35 percent of emergency room visits for substance use disorders.

[19]See GAO-17-146SP.

Forum participants also noted several strategies available in the education, health care, and law enforcement sectors for preventing illicit drug use:

- **Education.** Forum participants championed the use of school-or community-based prevention programs that research has shown to be successful in preventing illicit drug use and other behaviors. These programs include: *Life Skills, Strengthening Families Program: For Parents and Youth 10-14,* and *Communities That Care.* These programs focus generally on combatting a range of risky behaviors, giving participants skills to recognize and manage their emotions, and strengthening family and community ties.
- **Health care.** Forum participants identified and discussed three principle health care strategies for preventing illicit drug use: (1) having providers adhere to the CDC's guideline for prescribing opioids for chronic pain, (2) having providers use prescription drug monitoring programs (PDMP)—state-run electronic databases used to track the prescribing and dispensing of prescriptions for controlled substances—and (3) having primary care providers screen and intervene with patients at risk for illicit drug use.
- **Law Enforcement**. Forum participants identified four law enforcement strategies for preventing illicit drug use: (1) enforcing laws prohibiting underage consumption of alcohol and tobacco, (2) building trust between law enforcement and local communities, (3) using peers to promote drug-free lifestyles, and (4) closing prescription drug "pill mills" — medical practices that prescribe controlled substances without a legitimate medical purpose—and other efforts to reduce the supply of illicit drugs.

Forum participants also identified several high priority areas for future action to help prevent illicit drug use, including the misuse of prescription drugs. Some examples include:

- supporting community coalitions comprising the health care, education, and law enforcement sectors that work in concert to prevent illicit drug use at the local level;
- consolidating federal funding streams for multiple prevention programs into a single fund used to address the risk factors for a range of unhealthy behaviors, including illicit drug use;
- increasing the use of prevention programs that research has shown to be effective, such as those that are well-designed and deliver persuasive drug prevention messages on a regular basis;

- identifying and pursuing ways to change perceptions of substance abuse disorders and illicit drug use, such as emphasizing that a substance abuse disorder is a disease of the brain and can be treated like other diseases;
- supporting drug prevention efforts in primary care settings, such as exploring ways to reimburse providers for conducting preventative drug screenings; and
- reducing the number of prescriptions issued for opioids.

Agencies Have Strengthened Collaboration of Drug-Free Communities Support Program but Could Enhance Grantee Compliance and Performance Monitoring

In February 2017, we issued a report on the Drug-Free Communities Support Program (DFC)—a program that ONDCP and SAMHSA jointly manage. This program aims to support drug abuse prevention efforts that engage schools, law enforcement, and other sectors of a community to target reductions in the use of alcohol, tobacco, marijuana, and the illicit use of prescription drugs.[20] We examined the extent to which the two agencies (1) use leading processes to coordinate program administration and the types of activities funded, and (2) have operating procedures that ensure DFC grantee compliance and provide a basis for performance monitoring.

In 2008 we had previously reported that ONDCP and SAMHSA needed to establish stronger internal controls and had not fully defined each agency's roles and responsibilities for the management of the DFC program.[21] In our February 2017 report, we found that ONDCP and SAMHSA had improved their joint management of the program. Specifically, we found that ONDCP and SAMHSA employed leading collaboration practices to administer the DFC program and fund a range of drug prevention activities. For example, ONDCP and SAMHSA had defined and agreed upon common outcomes, such as prioritizing efforts to increase participation from under-represented communities. The two agencies also had funded a range of DFC grantees' activities and report on these activities in their annual evaluation reports. For example, ONDCP reported that from February through July 2014, grantees educated more than 156,000 youth on topics related to the consequences of substance abuse. Other examples of grantees' efforts included those

[20]See GAO-17-120.

[21]See GAO, *Drug-Free Communities Support Program: Stronger Internal Controls and Other Actions Needed to Better Manage the Grant-Making Process*, GAO-08-57 (Washington, D.C.: July 31, 2008).

that enhanced the skill sets of community members, including parents, to identify drug abuse or limit access to prescription drugs and those that reduced language barriers precluding non-English speakers from understanding drug prevention campaigns.

We also found that ONDCP and SAMHSA had operating procedures in place, but SAMHSA did not consistently follow documentation and reporting procedures to ensure grantees' compliance and had not accurately reported to ONDCP on grantee compliance. Based on a file review we conducted, we found that SAMHSA followed all processes for ensuring that the grant applicants whose files we reviewed had submitted required documentation before SAMHSA awarded them initial grant funding. However, SAMHSA was less consistent in adhering to procedures for confirming documentation in later years of the program. We found that the majority of grantees whose files we reviewed were missing required paperwork to document how they planned to sustain their programs after grant funds expired. Prior to our review, ONDCP and SAMHSA officials were not aware of the missing data in the grant files. We concluded that without close adherence to existing procedures, and a mechanism to ensure that the documentation it reports to ONDCP is accurate and complete, SAMHSA's performance monitoring capacity was limited. Moreover, SAMHSA could not be certain that grantees were engaging in intended activities and meeting their long-term program goals.

We made recommendations that SAMHSA develop an action plan to strengthen the agency's grant monitoring process and ensure ONDCP gets complete and accurate information, among other things. SAMHSA concurred with our recommendations and reported to us in April 2017 that it is implementing actions to address our recommendations that should be completed by this fall.

Chairman Gowdy, Ranking Member Cummings, and Committee members, this concludes my prepared statement. I would be happy to respond to any questions you may have.

GAO Contact and Staff Acknowledgements

For questions about this statement, please contact Diana Maurer at (202) 512-8777 or maurerd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this statement include Aditi Archer (Assistant Director), Joy Booth (Assistant Director), Julia Vieweg, Sylvia Bascope, Jane Eyre, Stephen Komadina, Mara McMillen, David Alexander, Billy Commons, and Eric Hauswirth. Staff who made key contributions to the reports cited in this statement are identified in the source product.

Chairman GOWDY. Thank you, Ms. Maurer.
Dr. Humphreys.

STATEMENT OF KEITH HUMPHREYS, PH.D.

Mr. HUMPHREYS. Chairman Gowdy, Ranking Member Connolly, and members of the committee, thanks for your leadership, and thank you for inviting me to speak to you today. My comments are informed by my 30 years as an addiction researcher and clinician, and also by my service at ONDCP where I was honored to serve in the Bush and Obama administrations.

As has been said, we're losing——

Mr. CONNOLLY. Mr. Humphreys, I'm sorry, if we can interrupt. It's very hard to hear you. You need to speak right into it like I'm doing.

Mr. HUMPHREYS. Okay. Is this better?

Mr. CONNOLLY. Much better. Thank you.

Mr. HUMPHREYS. All right. I hope you heard me say thank you for having me here today. Thank you for your leadership.

As has been said, we are losing over 50,000 Americans a year. To give my own comparison point, that's more than we lost to AIDS in the worst year of the epidemic.

ONDCP was set up actually to respond to the crack cocaine epidemic, but I think a modernized reauthorized ONDCP could be a very powerful force against this new and quite different epidemic.

ONDCP can coordinate the Federal policy process. If there's no one writing a national strategy, what happens is Federal agencies, some of them lose interest, not because they don't care, but just because they have a lot to care about at the Federal level. Also, sometimes agencies have competitive programs, duplicative program, or programs that have no evidence of effectiveness. So ONDCP's most important job is to herd the cats in Washington and get a strategy that is unified and effective. You can help them do that job better by giving out some more carrots and sticks.

So on the carrot side, providing some money for demonstration projects for ONDCP could help them entice agencies to try new drug policies or new programs. On the carrot side, ONDCP's power to review and decertify budgets could be strengthened so that the Director of ONDCP was the final word on that, rather than usually having to yield to OMB.

Related to that, there is a notification requirement in the 2006 reauthorization that says Congress must be notified when there's a decertification. That has made directors very wary of using decertification. It hasn't been used in years. And you might consider dropping that, letting the executive branch work among itself and get on the same page before they come to you with their ideas.

Last, I hope you would urge the President to put the ONDCP director position back in the Cabinet. That gives a really strong message to the bureaucracy that we're taking drug policy seriously.

Another critical role for ONDCP is to serve as a resource to the White House and to Congress on the role of addiction issues in mainstream healthcare. Just give you an example on that, a very current example. Many people aren't aware that Medicaid is now the lead funder of opioid addiction treatment in this country. So it's

important for ONDCP to be a voice to say, if we curtail that program, we, by definition, curtail treatment for this problem.

ONDCP would also be helpful with Medicaid and other programs in being the voice for procedures and policies. We have to reduce the likelihood that opioid prescriptions are inappropriate, which is a challenge for all health insurers. ONDCP has been less influential on healthcare policy than it could have been because it was created primarily as a domestic and law enforcement agency, and its staffing, its knowledge base, and its strongest relationships reflect that heritage.

Law enforcement is extremely important in drug policy and it always will be. But health policy is also really important, and it might even be more important for the opioid epidemic, which after all, was started not by criminal gangs, it was started in the healthcare system. Congress could support a broader role for ONDCP and healthcare policy by better balancing the focus of the agency's authorization. Just as one crude indicator of what the last authorization asked ONDCP to do, my own count is that the text mentions interdiction 40 times, enforcement 98 times, and healthcare only once.

Congress could also mandate a bigger role in the drug policy development process for major healthcare agencies like the CDC, the FDA, and CMS. Congressional guidance regarding ONDCP staffing to ensure they have good in-house health policy expertise could also help.

Finally, with Congress's help, ONDCP could improve drug policy through targeted research efforts. To take a prominent example of why this matters, we really do not know how many people are addicted to heroin in this country. The measures just aren't that good. Giving ONDCP a bit of some funding to either conduct research or commission research on critical drug policy questions like that would reap huge rewards for the development of policy and also its evaluation.

In closing, I want to emphasize we're in the midst of one of the worst drug epidemics in the history of our Nation. With the right support from you, the White House Office of National Drug Control Policy can lead the government and the country in a coordinated, effective, and lifesaving response to this horrifying epidemic.

Thank you for your time, your leadership, and I look forward to your questions.

[Prepared statement of Mr. Humphreys follows:]

Testimony of Keith Humphreys to U.S. House of Representatives

Committee on Oversight and Government Reform

July 26, 2017 Hearing on Reauthorization of the White House Office of National Drug Control Policy

Chairman Gowdy, Ranking Member Cummings, thank you for your leadership on drug policy and for inviting me to speak with your committee. My name is Keith Humphreys and I am the Esther Ting Memorial Professor at Stanford University School of Medicine. My comments today reflect my 30 years of work as a clinician and researcher in the addiction field, as well as my experiences at ONDCP. Specifically, I served as an appointee of President George W. Bush on the ONDCP-supported White House Advisory Commission on Drug-Free Communities and subsequently served inside the Office as Senior Policy Advisor for the first year of the Obama Administration.

Over 52,000 Americans died in 2015 from drug overdoses, a higher annual toll than AIDS caused at the peak of that epidemic. This crisis should be foremost in our minds as we think about what ONDCP is for and what it should be authorized to do. The Office was created in response to the crack cocaine epidemic and the last time it was reauthorized, over a decade ago, methamphetamine was foremost on the policy agenda. ONDCP's authorization language reflects the concerns of those prior eras and includes very little direction relevant to our current leading drug problem, which emerged from an historically and internationally unprecedented surge in legal opioid prescriptions and has more recently spilled over into black market heroin and fentanyl. A modernized, re-authorized ONDCP could be a powerful force pushing back against the current epidemic in the following 4 ways.

First, a White House Drug Policy Director can educate and rally the American people, who are the world's best force multiplier when they are engaged on a social problem. Like many professionals in the addiction field, I am contacted virtually every week by strangers who are suffering due to the opioid epidemic. Most of them are scared and confused about what to do. Desperate family members do not know which treatments will actually work for their addicted loved one and others don't even know that addiction is treatable at all. Most people who could benefit from having the overdose rescue medication naloxone on hand do not know what it is or how to get it. Parents I talk to don't know to take advantage of prescription drug take back programs so that their teenage children can't rummage through the medicine cabinet and set themselves on a dangerous course. In all these cases and more, ignorance isn't bliss; it's positively dangerous.

A Presidentially-appointed ONDCP Director could cut through the fog with information and inspiration regarding the opioid epidemic. Congress therefore should be strenuously urging The President to nominate a White House Drug Policy Director immediately. Acting Director Baum is a remarkably talented and dedicated civil servant, but it takes a presidential appointee to gain a platform in the media and with the country. The President's Commission on Combatting Drug Addiction and the Opioid Crisis comprises enormously knowledgeable and committed individuals, but Commissioners are busy people with many responsibilities outside of drug policy, and in any event the Commission is slated to go out of existence in two months. A Presidentially-appointed, Senate-Confirmed ONDCP Director is thus essential for commanding attention in the public square as we face the opioid epidemic in the coming years.

Second, ONDCP can inform and coordinate a strategic federal response to the opioid epidemic. Without a coherent national drug control strategy in place, some critical federal agencies will lose interest, not because they don't care but because there is a lot to care about at the federal level. At other times, agencies create overlapping or even competitive drug control programs, or become enthusiastic about programs that have little objective evidence of effectiveness. ONDCP's most important role within Washington is to herd the relevant cats and make federal drug policy unified and effective.

Congress could enhance the effectiveness of this policy coordination process by equipping ONDCP with more carrots and sticks. On the carrot side, providing ONDCP with some discretionary funds for demonstration projects would help it entice agencies to work together to implement new drug policies. In terms of sticks, ONDCP's power to review, certify, and, if needed, de-certify federal agency drug control spending requests could be enhanced so that the ONDCP Director has the final word on these matters rather than yielding to OMB. Congress should also strongly encourage the President to put the ONDCP Director back in the cabinet, which would serve as a powerful signal to the bureaucracy that drug policy is a priority that agencies must take seriously.

A third critical role for ONDCP is to serve as a resource to the White House and Congress regarding how to consider addiction-related issues within mainstream U.S. health care policy. To give a current example: as major changes to the Medicaid program are being weighed, ONDCP could enhance awareness that Medicaid is the largest single insurer covering opioid addiction treatment in this country, meaning that scaling back Medicaid would sharply reduce addiction treatment availability. ONDCP could be equally important making Medicaid work better, for example by being the voice for policies that have evidence of reducing the likelihood that Medicaid recipients -- as well as enrollees in other insurance programs -- are inappropriately prescribed opioids.

ONDCP is less influential on health care policy than it could be because it was created primarily as a domestic and international law enforcement agency; its knowledge base, staffing and interagency relationships reflect that heritage. Enforcement remains essential in our response to drug epidemics, but health policy is equally important, particularly in the case of the opioid epidemic which after all was started not by criminal gangs but within the health care system itself.

Congress could support a broader role for ONDCP in health care policy by better balancing the focus of the agency's authorization. Just as one crude indicator of what the last authorization asks ONDCP to do, by my count the text mentions "interdiction" 40 times, "enforcement" 98 times, and "health care" only once. Congress could also mandate a bigger role in the drug policy development process for the major health care related agencies, such as the Centers for Disease Control and Prevention, the Food and Drug Administration and the Centers for Medicare and Medicaid Services. Congressional guidance regarding ONDCP's staffing that ensured strong in-house expertise on health policy would also be valuable.

Finally, with Congress's help, ONDCP could improve drug policy through targeted research efforts, a role it had for many years before the relevant appropriations were reduced. To take a prominent example of why this matters, consider that our current measurement methods are completely inadequate for determining how many Americans are using and addicted to heroin. As a result both Congress and the Executive Branch are flying blind, unable to know if current policies are increasing or reducing heroin use. Restoring funding to ONDCP to conduct or commission research on this and other high-priority drug policy questions would reap massive returns in the development and evaluation of U.S. drug policy.

In closing, I would emphasize that we are in the midst of one of the worst drug epidemics in the history of our nation. If this is an average day in America, more than 100 of our fellow citizens will die of a drug overdose, most of them from opioids. With the right support from Congress, the White House Office of National Drug Control Policy can lead the government and the country in a coordinated, effective, and life-saving response to this horrifying and heartbreaking epidemic.

Thank you for your attention, time, and leadership. I look forward to your questions and comments.

Keith Humphreys, Ph.D.
Esther Ting Memorial Professor
Stanford University School of Medicine

Chairman GOWDY. Thank you, Dr. Humphreys.

Mr. FLATTERY. And all the members would also like to recognize and welcome your wife, who is with you today as well. You're recognized.

STATEMENT OF DON FLATTERY

Mr. FLATTERY. I join others in thanking you, Mr. Chairman, Ranking Member Connolly, at least for today, and other members of the committee, for conducting this hearing about reauthorization of the Office of National Drug Control Policy. It's a much needed discussion to ensure the Federal Government is prepared to fight to end the epidemic of prescription drug and heroin addiction the country is facing. And while I strongly support, as an advocate, the activities of ONDCP, my purpose in this discussion today is not to drill down and discuss individual activities in any detail.

My name's Don Flattery, and until recently, I lived in Fairfax County, Virginia. I'm a former Federal manager; a recent member of the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse; a policy advisor to the national addiction-fighting nonprofit, the FED UP! Coalition; and I'm an active participant in my newly adopted county of Brunswick, North Carolina's addiction task force.

But I'm not here today in any of those roles. I'm addressing the committee solely as a grieving parent, someone who's lost his 26-year-old and only son to an opioid overdose less than 3 years ago.

In prior committee hearings, you've heard the appalling statistics about the explosion of opioid prescriptions addiction rates over overdose deaths. I'm intimately aware and familiar with them and I'll not repeat them here, but those discussions are often far too clinical.

As you, Federal officials, elected officials, State officials, and public health practitioners deliberate and consider solutions, it is far too easy to become detached. As you proceed, I implore you to recall the personal impacts. We are not just speaking about shocking, obtuse statistics. We're speaking about my son, your daughter, and our neighbors. They're real people with real lives, suffering from a disease, and their losses are the face of the epidemic that we must stop.

Allow me to briefly share my son's story. On Labor Day weekend 2014, my family lost my 26-year-old Kevin to an opioid overdose. Like so many swallowed by this crisis, Kevin enjoyed the blessings of a typical suburban upbringing, attending private schools, participating in youth sports and high school athletics. He came from a loving two-parent home and leading the quintessential middle class life, enjoying all of life's and God's blessings.

He was a good student and was a graduate of the local all male prep school, Gonzaga, right here in Washington, D.C., and later the University of Virginia, where he actively participated in student and fraternity life. Kevin came to his addiction as a working adult while pursuing his talent and passion working in the film industry in Hollywood and New York City. He'd been exposed to opioids as a teen after an injury, and he told me himself that he thought nothing of them. Like so many, he underestimated them.

While working, he began self-medicating issues with anxiety and depression with the widely available opioid prescription drug, OxyContin, which is a common story, as many struggling with coincident mental health issues develop addiction problems. He quickly became dependent and then addicted. He returned home to Virginia in the fall of 2013 to his family seeking treatment and support. Like many struggling in search of treatment, he tried a wide variety of pathways, including detoxification, medication-assisted programs, and an outrageously expensive 28-day abstinence only residential program.

Some of these were covered by insurance, but others were covered out of pocket. But like others in pursuit of recovery, he experienced the painful and very common process of seeming progress followed by relapse. Days before he was to start a program of the medically assisted treatment drug, naltrexone, he used again and he did not recover.

The short bio description I just gave you is an example of how the scourge of the opioid addiction epidemic before us today has no stereotypical victim. It's affecting people of all walks of life, all income levels, and all backgrounds. This epidemic—and make no mistake, this is an epidemic—and my son's addiction do not respect income, social status, or intelligence. That's what epidemics do. That point bears repeating in every hearing this committee and others conduct which touch upon this health crisis.

Since my son's loss, I've learned a great deal about the disease of addiction, the current epidemic, and it's underlying causes, and painfully, for me and my wife, some evidence-based treatment opportunities that offer hope, but now only for others. From the perspective of an impacted parent, as a citizen, and as an advocate, I would like to add my voice to thousands traveling the same journey about some imperatives needed to stem the tide of the epidemic.

The first is the primary topic of this very hearing. The need for a strong well-resourced and effective ONDCP has never been more important. A policy office directly tied to the Office of the President not only sends a message to the public about the importance of effective drug policy, but it also ensures more effective development of integrated, cross-Federal Government programs and policies. ONDCP plays an essential role in being an integrator and a coordinator for the widely disparate addiction-fighting efforts of HHS, SAMHSA, NIDA, CDC, the FDA, as well as programs in the VA, DOD, Indian Health Service, and a wide variety of law enforcement agencies. Interagency discussions and collaborations will be ineffective without the singular collaboration entity empowered to work across stovepiped efforts and programs.

The second imperative is continuous coverage of addiction treatment. Access to medication-assisted treatment already remains elusive for far too many patients. Changes to the Nation's healthcare system that remove mental health and substance use disorder coverage as an essential benefit will be a disaster for many, including those like my son, seeking such help. We must find ways to expand, not limit, access to addiction fighting medications, and ensure insurance companies and providers do so at a reasonable cost.

Mr. Chairman and members of the committee, thank you again for addressing the need for an effective ONDCP as part of the Federal Government's response. We need to ensure Federal entities do their part to appropriately protect our loved ones and the public health. Americans suffering from this scourge deserve no less. Thank you.

[Prepared statement of Mr. Flattery follows:]

Testimony of Don Flattery
Citizen Advocate and Impacted Parent
House Oversight and Government Reform Committee
July 26, 2017

Mr. Chairman, Ranking Member Cummings and members of the committee, thank you for conducting today's hearing about authorization of the Office of the National Drug Control Policy. It is a much needed discussion to ensure the federal government is prepared to fight to end the epidemic of prescription drug and heroin addiction the country is facing.

My name is Don Flattery and until recently lived in the Mt. Vernon area of Fairfax County, Virginia. I am a former federal manager, a recent member of the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse, a policy advisor to the national addiction-fighting advocacy non-profit, the FED UP Coalition, and I am an active participant in my new adopted county of Brunswick, North Carolina's addiction task force. But I am not here today in any of those roles. I am addressing the committee solely as a grieving parent, someone who has lost his 26 year old and only son to an opioid overdose less than three years ago.

It is critically important to me and to my wife that we do our part to ensure that discussions about this scourge are personalized. In prior committee hearings, you have heard the appalling statistics about the explosion of opioid prescriptions, addiction rates and overdose deaths. I am intimately familiar with them and will not repeat them here. But those discussions are often far too clinical. As you, federal officials, state officials and public health practitioners deliberate and consider solutions, it is far too easy to become detached. As you proceed, I implore you to recall the personal impacts – we are not just speaking about shocking, obtuse statistics – we are speaking about my son, your daughter and our neighbors. They are real people, with real lives, suffering from a disease and their losses are the face of the epidemic we must stop.

Allow me to briefly share my son's story. On Labor Day weekend, 2014, my family lost my twenty-six year old Kevin to an opioid overdose. Like so many swallowed by this crisis, Kevin enjoyed the blessings of a typical suburban upbringing, attending private schools, participating in youth sports and high school athletics. He came from a loving two-parent home and led the quintessential middle class life, enjoying all of life's and God's blessings. He was a good student and was a graduate of a local all-male prep school in Washington, DC and later the University of Virginia where he actively participated in student and fraternity life.

Kevin came to his addiction as a working adult while pursing his talent and passion working in the film industry in Hollywood and New York City. He had been exposed to opioids as a teen after an injury and told me himself that "he thought nothing of them".

Like so many, he underestimated them.

While working, he began self medicating issues with anxiety and depression with the widely available opioid prescription drug OxyContin – which is a common story as many struggling with mental health issues develop co-incident addiction problems. He quickly became dependent and then addicted. He returned home to Northern Virginia in the fall of 2013 to his family, seeking treatment and support.

Like many struggling in search of treatment, he tried a variety of pathways including in-patient detoxification, intensive out-patient, medication assistance with buprenorphine, step program support and an outrageously expensive 28-day abstinence only residential program. Some of these were covered by insurance but others were covered out-of-pocket. But, like others in pursuit of recovery, he experienced the painful and common process of seeming progress followed by relapse. Days before he was to start a program of the medically-assisted treatment drug, naltrexone, he used again, and did not recover.

The short bio description I just gave you is an example of how the scourge of the opioid addiction epidemic before us today has no stereotypical victim. It is affecting people of all walks of life, all income levels and all backgrounds. This epidemic and my son's addiction do not respect income, social status or intelligence. That's what epidemics do. That point bears repeating in every hearing this committee conducts which touch upon this health crisis.

Since my son's loss, I have learned a great deal about the disease of addiction, this current epidemic, its underlying causes and painfully for me and my wife, some evidence-based treatment opportunities that offer hope, but now, only for others.

From the perspective of an impacted parent, as a citizen and as an advocate, I would like to add my voice to thousands traveling the same journey about some imperatives needed to stem the tide of the epidemic before us.

The first is the primary topic of this hearing. The need for a strong, well resourced and effective ONDCP has never been more important. A policy office directly tied to the Office of the President not only sends a message to the public about the importance of effective drug policy but it also ensures more effective development of integrated, cross-federal government programs and policies. ONDCP plays an essential role in being an integrator and coordinator for the widely disparate addiction fighting efforts of HHS's SAMHSA, NIDA, CDC and FDA as well as programs and activities in the VA, DOD and Indian Health Service. Interagency discussions and collaborations will be ineffective without this singular collaboration entity empowered to work across stove-piped efforts and programs. Addiction fighting advocates are pleased with ONDCP's emphasis on addressing the opioid addiction epidemic as a public health and not criminal justice issue, with the Drug Free Communities Program empowering local communities to address prevention at a local level and for its' championing expanded access to evidenced-treatment. Loss of the recent momentum created by ONDCP in these areas would be seen as a significant blow to the fight to end the epidemic.

The second imperative is reliable, continuous coverage of addiction treatment, especially medication-assisted therapy, as an essential benefit under any proposal to re-engineer our nation's health care system. Even with a good family insurance plan and the benefit of continued young-adult coverage provided by the Affordable Care Act, finding physicians with authorization to prescribe buprenorphine was difficult for my son. We must find ways to expand the number of physicians prescribing addiction fighting medications and also ensure insurance companies and providers do so at a reasonable cost.

Access to medication-assisted treatment already remains elusive for far too many patients – changes to the nation's health care system that remove mental health and substance use disorder coverage as an essential benefit will be a disaster for those, like my son, seeking such help.

Contemplated reductions in Medicaid coverage, which is now providing addiction treatment to vast numbers of people previously without any help, may become a death sentence for some. Finally, substitution of a possible opioid fund to offset Medicaid coverage, subject to annual appropriations decisions, is not an effective solution for a continuously expanding public health crisis.

Mr. Chairman and members of the committee thank you again for addressing the need for an effective ONDCP as part of the federal government's effort to combat the opioid addiction crisis. We need to ensure federal entities do their part to appropriately protect our loved ones and the public health. American's suffering from this scourge deserve no less.

Chairman GOWDY. Thank you, Mr. Flattery.

We'll now recognize the gentleman from Oklahoma, Mr. Russell, for his questions.

Mr. RUSSELL. Thank you, Mr. Chairman. And thank you, panel, for being here today. I agree with all of the statements that have been made.

And, Mr. Flattery, you know, you certainly bring—you and your wife bring this issue—put a personal face on it. It affects so many. I have also seen the devastating effects of overmedication in trying to treat veterans, as a combat veteran myself, and seeing a number of folks as they try to come home. It seems to be the simple thing is just to give warriors a bag of cocktail-type of medications, and then now they're on addictions. And then we wonder why the returning veteran came home and, quote, committed suicide, when it may have been the direct effects of overmedication and addiction.

It seems to me, Mr. Chairman, that we all bear responsibility for this. It was Congress that made the decision to relax the laws that allowed more over-the-counter direct access to what I consider to be legalized heroin.

So I guess my first question, and whoever would like to comment, but we'll start with you, Mr. Baum. And thank you for your dedicated years of service in dealing with difficult issues.

What legislatively could we do? We let the genie out of this bottle by relaxing the access. You know, I go home, even in the great State of Oklahoma, you'll see these pain and injury centers everywhere. Somebody can walk in and the next thing you know, some physician may sign off and, you know, you can go off with a bag of pills.

What legislatively would you like to see done with the decades of retrospect and how we got here?

Mr. BAUM. Congressman, thank you for your question. There are a lot of things that we can do more of. And, you know, I guess I would start by saying, when we're in a crisis and so many people are dying, we need to do more of everything. So I would love to see tighter restrictions on use of the narcotic analgesics. I don't think the evidence is there to have these substances used as a default for chronic prescriptions. You know, once—the data is very clear. Once someone is using these substances for more than 5 days, their addiction rates go up dramatically. So tighter controls on that.

Certainly, resources for prevention, treatment, and medication-assisted treatment. We have lots of very clear evidence that people do well on medication-assisted treatment. Everyone should be offered it. If you look at the data, only about a third of the people with a diagnosed opioid use disorder actually now have access to treatment.

And let me say one last thing, and maybe turn it over to my colleagues, is that 80 percent of people with a substance use disorder do not come forward for treatment. So we don't just need to get better high-quality treatment to those who are on a waiting list; we need to go out and find the people out there and bring them in and control them and encourage them to get the help that they need.

Mr. RUSSELL. Thank you, sir.

And anyone else who would care to comment.

Mr. HUMPHREYS. Congressman, I just want to give you an important piece of information about how much prescription opioids Americans consume. On a per capita basis, we are the world leader by an enormous margin, six times what European countries prescribe. We could cut prescribing by 40 percent and we would still be the world leader in opioid prescribing. So that is the biggest wheel.

There are many good policies, treatment, prescription monitoring, and so forth, but that's the fundamental thing, is we're just prescribing way too much.

Mr. RUSSELL. Okay.

Ms. Maurer?

Ms. MAURER. Yeah. When the comptroller general convened the panel of experts last year, that was one of the topics of discussion precisely, what you just asked about. And there were some common themes that came across from that body of experts, and one was exactly what Dr. Humphreys just talked about. First and foremost was prescribe fewer opiate medications.

But hand in hand with that was also a theme of providing additional education to providers. The CDC has some guidelines—some recently updated guidelines that apparently the word has not gotten out fully on those things. Prescription drug monitoring programs are an important part of this. And as well as on the law enforcement side, continuing aggressive investigation and prosecution of pill mills.

Mr. RUSSELL. Thank you.

Mr. FLATTERY. If I may, just to add to that. The recent activities have been somewhat successful in reducing the number of prescriptions. The U.S. with 5 percent of the world's population is consuming 80 percent of the world's opioids. Voluntary prescribing guidelines, development of PDMP systems are having an impact.

Last year, prescriptions in this country declined to over 220 million prescriptions. That's still enough for every American to have their own prescription bottle for 30 days. These prescription drugs are continuing to flood our communities, our workplaces, our schools, and our medicine cabinets, making them available for medical overuse and for abuse.

You asked the core question, what can you do legislatively. We need our State partners, because they are responsible for managing the practice of medicine, and we need them, and they are, we are beginning to see some progress in State capitals addressing the overprescription of opioid drugs.

Mr. RUSSELL. Thank you.

And thank you, Mr. Chairman, for you indulgence. I yield back.

Chairman GOWDY. The gentleman yields back.

The gentleman from Virginia is recognized.

Mr. CONNOLLY. I thank the chair. And again, I thank the panel for their very cogent testimony.

Mr. Baum, this is a hearing on the reauthorization of your office. Has the administration or has your office submitted a draft reauthorization bill to the Congress?

Mr. BAUM. Mr. Connolly, we have not, but we do have some considered thoughts and would be happy to discuss some of those——

Mr. CONNOLLY. Well, we need a reauthorization bill from somebody, even if we decide to go a different direction. Any idea when it might be submitted?

I mean, the chairman pointed out, I think the last reauthorization was 2006, so it's grown stale. We heard Dr. Humphreys point out, you started out originally as a crack cocaine focus, things have changed. Reauthorization's got to take cognizance to that. We want to be supportive, but we've got to have some kind of timeframe in which you're going to—not you personally—the office and the administration are going to interact with Congress that ultimately has to do the reauthorization.

Any idea when we might see a draft?

Mr. BAUM. I don't want to give you a timeline, but I can tell you this. I've studied the issue very closely. We know what we need to do.

Mr. CONNOLLY. Okay.

Mr. BAUM. We can put together a reauthorization bill and work with our partners in the administration and get something to the Congress relatively rapidly. So I look forward to the——

Mr. CONNOLLY. I don't presume to speak for the committee, but I think as you can hear, on a bipartisan basis, we're seized with this mission and urgency, and I hope you'll take it back. We want to see a reauthorization. We're happy to help, but—okay.

Mr. BAUM. We want to see it too. We're eager to move out on it.

Mr. CONNOLLY. Likewise, we need a strategy. Any idea when a strategy will be submitted to the Congress?

Mr. BAUM. I have a very precise idea.

Mr. CONNOLLY. Okay.

Mr. BAUM. I'd be happy to discuss that, and I know Mr. Gowdy raised it as well. We're developing a strategy now. You know, I do want to say that I take the deadlines that—the statutory deadlines extremely seriously, and I know what the deadline is, February 1. In the Trump administration we are developing a strategy, we have a draft, we're consulting both formally in terms of letters to Members of Congress. I've been traveling, holding meetings. I'm holding interagency meetings. We are working a conference of strategy——

Mr. CONNOLLY. Again, I'll stipulate to all that. Look, I only have 5 minutes.

Mr. BAUM. Yeah, sure.

Mr. CONNOLLY. When can we see it?

Mr. BAUM. The deadline is February 1 of next year, and there is an issue with—we are required to wait until the President's budget comes out, but sometimes it is a few weeks after. But early next year, you'll have a comprehensive drug strategy from the administration hovering the entire scope of the issues.

Mr. CONNOLLY. All right. Well, let me invite you, even in draft form, if you can, to start, because we want to be partners. And the urgency of the subject, you know, I think demands executive and legislative branch cooperate as much as we can. So that strategy, you know, I hope will reflect the realities so many Members are experiencing in their respective districts. And so we'd be glad to work with you, but we've got to have some kind of draft to start with.

Likewise, what about the appointment of a director? And I think you're perfect, you're my constituent. How can we do any better

than you? But we still don't have—it's been 6 months, and you're not alone, there are a lot of vacancies in the executive branch, but this one's pretty critical. Any idea when we might hear a name floated, let alone actually someone nominated?

Mr. BAUM. Well, thank you for that strong endorsement. I appreciate that.

Mr. CONNOLLY. I won't help you with Donald Trump, but——

Mr. BAUM. I'm——

Mr. CONNOLLY. I can bad mouth you if that would help.

Mr. BAUM. You know——

Mr. CONNOLLY. Donald, this man's a loser. Don't do it.

Mr. BAUM. Can I take back my time then?

Mr. CONNOLLY. Yeah, yeah, yeah. It's actually my time, but go ahead.

Mr. BAUM. We appreciate the thought. We know that they're working on filling these positions. It's a critical position, and as soon as we have something to report, you'll be the first to know.

Mr. CONNOLLY. Well, that's so comforting. All right. Thank you.

Mr. Flattery, I want to go back to your testimony. And thank you so much for being willing to share. Thank you to your wife for coming up here.

You mentioned your—well, first of all, and I don't—if the chair will just indulge me in this line of questioning for a little bit to draw out a little bit more the story of Kevin.

So your son wasn't hanging around with the wrong kind of crowd that was into drugs and that's how he ran into trouble. That's not how his problem began, is it?

Mr. FLATTERY. No, it is not. My son did not, as many unfortunate young people do, he did not surrender his youth, he did not turn his back on his activities and friends and school work. He became addicted as a working adult pursuing what he was passionate about.

Mr. CONNOLLY. But he became addicted. What triggered the need—or his perceived need for the use of an opioid?

Mr. FLATTERY. In my son's case, my wife and I believe that he began medicating issues with—self-medicating issues with a widely available drug.

Mr. CONNOLLY. No. But why?

Mr. FLATTERY. Because like many people who develop addiction problems, they often have coincident psychosocial issues that have to be dealt with, and that's why pairing of mental health services and addiction treatment services is so critical.

Mr. CONNOLLY. In his case, he was in New York trying—he was an aspiring film maker?

Mr. FLATTERY. At that time, he was in Hollywood.

Mr. CONNOLLY. In Hollywood. All right.

Mr. FLATTERY. And he was exposed to widely available OxyContin and very inexpensive OxyContin.

Mr. CONNOLLY. He came home?

Mr. FLATTERY. He did.

Mr. CONNOLLY. And he, from your point of view, made a really good-faith effort to try to lick this, correct?

Mr. FLATTERY. Yeah. Sort of adding to our own personal tragedy, our son was completely cooperative in trying to pursue treatment.

He recognized that he had fallen into the rabbit hole and he was in over his head. He was seeking our support. He tried a number of pathways. And they're common pathways. Detox, intensive outpatient support from Inova Fairfax Hospital. He was on a regimen of buprenorphine, also known as Suboxone, and he still struggled with it. He attended peer support through AA and NA. But at one point, he same to us and said, you know, I just—he began to manipulate his own Suboxone, because it's a self-administered medication. And he said, you know, I think I would like to try a residential treatment program.

And I do have issues with my son's experience in residential treatment. Many, not all, residential treatment programs often use a detoxification, and then couple either cognitive behavioral talk therapy during the 30-day stay with what I consider to be reformulated step program dogma, which is available for free in church basements all over the country. Those programs, at least the program that my son encountered, are very expensive, $28,000 to $30,000 a year. Those types of programs, I think, are emblematic of why our treatment system is broken.

Many families will do anything in their power to get help for their loved one, as we would. And many families are bankrupting themselves sending them to such facilities that then after the 30-day stay, release them to the wild. And they often are treating the people who attend, not as patients, but as customers. And the disease of addiction is a chronic, reoccurring issue that has to be dealt with over a long period of time.

And in my son's case, he was not ready to be released to the wild after 30 days. It's not a magic fix. And our treatment system has to be reengineered to provide long-term care for a chronic condition, and that's, in my estimation, where my son's journey broke down.

Mr. CONNOLLY. Thank you.

Mr. Chairman, you've been gracious. I thank you.

Chairman GOWDY. The gentleman yields back.

The gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Chairman. And I thank the witnesses today for appearing on this extremely important topic.

Mr. Flattery, you and your wife have become way more involved in this issue than you probably ever hoped to since the loss of your son. You'd mentioned a couple of times here to Mr. Connolly and in your opening statement about the ease of access of opioids, specifically OxyContin. Can you explain a little further what your understanding is of why these are so easy to get and why they're so inexpensive?

Mr. FLATTERY. Well, I'll first start with the basic essence of the anatomy of this epidemic. This is, as Mr. Humphreys indicated, this wasn't started by drug dealers who had built a business model around providing illicit drugs. This had its origins in the medical community, and I believe you are a medical practitioner yourself and understand that.

In an attempt to be compassionate in the treating of pain, American physicians use their prescription pad. American physicians also have a deficiency in prior training on proper pain management

and addiction management. There isn't even a whole discipline built yet around addiction management in medical schools.

So in an attempt to provide compassionate care, American physicians are implicated in the overuse of opioid drugs for all manner of pain conditions for which they were never intended. They started out as a drug that was to address terminal cancer pain and recovery from acute injuries, and it drifted into the use of opioid drugs for migraines, arthritis, indiscriminate lower back pain. In the dental community, for wisdom tooth extraction. And they not only were being overprescribed, they were being prescribed in quantities that were completely unnecessary for the treatment of an acute condition. And as Mr. Baum indicated, long-term use of opioid drugs lead to addiction.

Now, you asked the question about why so ubiquitous. And the answer is, in 2013, we hit the peak year in the U.S. with over 259 million prescriptions. That's a number in the billions of individual doses. And those drugs are flooding communities and workplaces, and they're just widely available, and they're available for potential misuse. So they're available at low cost on the street.

Mr. DESJARLAIS. Okay. Mr. Baum, is there currently any legal requirement for prescribers, physicians, nurse practitioners, to fully educate their patients on, not only the harms addictive properties of these medications, but also to educate them on the dangers and illegality of sharing these medications with other people?

Mr. BAUM. Thank you for the question. There is no requirement from mandatory prescriber education, and frankly, I am very concerned about that. I know in the previous administration, there was discussion about increasing voluntary prescriber education. But looking at the progress, I don't think it's been nearly enough. And I think it's something that we ought to talk about making it mandatory. To make sure at least those prescribers that are putting these very, very powerful drugs in the hands of our citizens, spend a few hours learning about the risks and about addiction, I think would be important, and it's something that we should talk about.

Mr. DESJARLAIS. I think it's, yeah, probably more than something we should talk about. As a former physician and current holder of a DEA license, I know that I would make it a point to educate my patients on the power of these drugs. But, also, I think there's responsibility among the patients to know that it should be illegal to share these drugs. I have a license, went to medical school to prescribe them, but patients often will just share it with family and friends thinking that it's okay. That should be a crime. And it probably is, but it's not enforced.

And if one of the problems is overprescribing, that needs to be stopped. And physicians and medical students and all prescribers should be educated in medical school on this issue. Because of the scope of this problem, the time is ripe to do that.

But, also, I think that it is a patient's responsibility to properly handle these medications, and there should be laws and documents that a patient should sign when they pick up this prescription, either from the pharmacy or when physicians prescribe it. Would you be willing to look at that as an option?

Mr. BAUM. Yeah, I'm absolutely willing to look at it. But I really think the major responsibility is with the prescribers. When you have an injured kid that you're taking to the doctor and the doctor gives you your prescription to take pills for 30 days or 60 days and you get your bottle of bills with the directions, the tendency is to follow the directions, and now we're putting it on parents to ask the doctor, hey, should my—does my kid really need to take this for 30 days for a wisdom tooth extraction. And I think it should be the other way. The doctors are the experts. They're the one in the white coats. They're the ones with the responsibility to think about the powerful medications they're putting in the hands of our citizens.

Mr. DESJARLAIS. And I'll promise you that the vast majority of all doctors feel the same way. They don't want to harm patients with these medications. They don't want to prescribe irresponsibly. They are always bad actors, and that's who we need to focus on.

I think that that door swings both ways. Physicians definitely should take the brunt of the responsibility. I also think that law enforcement should focus on people who share or sell these medications, because as a physician, that was always a concern of mine. If I was treating someone with chronic pain or even cancer, you just assume that those people are taking the prescriptions properly. That's not always the case. And I have all kinds of stories where I found out people were being put in very vulnerable situations by family members to get these prescriptions so they could go out and sell them, and so they were forced to lie to me. I didn't know I was doing the wrong thing, and I know other physicians are in the same situation where they get tricked or duped into thinking people have critical problems or illnesses.

And so I do think the enforcement side of that needs to be ramped up as well, but there's a dual responsibility. And the bottom line is we have a huge number of people dying every year, and it's not time to think about what we should do, we should be doing it. And I'm happy to work with you further on this issue.

And thanks to the chairman for giving me the additional time. I yield back.

Chairman GOWDY. The gentleman from Tennessee yields back.

The gentlelady from the District of Columbia is recognized.

Ms. NORTON. Thank you very much, Mr. Chairman. And I want to first thank you for this hearing. It's a very timely hearing. And I appreciate the bipartisan way in which this hearing is being held. This is an across-the-board problem. Already I've heard ideas, including from my colleague on the other side, as to the kinds of things we need to be thinking about, and for reauthorization.

I thought the President had begun in a bipartisan way himself when early on he said he thought that we should—and here I'm quoting him, show great compassion about the opioid epidemic. And then the Office of Management and Budget virtually abolished your agency with a 95 percent cut. And here is where bipartisanship mattered. There was an outcry on both sides of the aisle, and I think in the only—or one of the few circumstances where I have seen the OMB take back its mark, it did. And now I understand only a 5 percent cut.

And, Mr. Chairman, could I ask that the letter from the ranking member, Elijah Cummings, and from Representative Johnson, a Republican from Ohio, was signed by 75 members asking that this cut be reversed. It worked. And I ask that that may be made part of the record. Mr. Chairman, is that a part of the record?

Mr. DESJARLAIS. [Presiding.] Without objection.

Ms. NORTON. Thank you, sir.

First, let me mention the statement by Mr. Connolly. It was kind of a very telling critique of current marijuana policy. We all know, I don't care what side of the aisle you sit on, that marijuana is, per se, legal in the United States, certainly by people younger than anyone on these panels, other than—younger than 40, let me say, to be gracious.

Yet Congress has prohibited the District of Columbia from using its local funds to tax and regulate marijuana, tried to keep the District from indeed making possession of only 2 ounces legal, but Congress didn't know how to write an appropriation rider that would do that effectively. So here is what we have. The unintended consequences of no regulation, no taxation, as eight States do, but you can possess marijuana.

Ms. NORTON. So what we've done in the District of Columbia is we have expanded the underground market for marijuana. Indeed, it's nicknamed in the District the drug dealer protection act. And The Washington Post actually identified a marijuana dealer, and he said it was a license for me to print money.

Now, there are members of this committee who are from some of the eight States that have legalized marijuana. They are Alaska, California, Colorado, Maine, Massachusetts, Nevada, Oregon, Washington State, and Washington, D.C.

My question for Mr. Baum is if D.C., if the District of Columbia, could tax and regulate marijuana, would that have the effect of at least partially undermining the illegal marketplace for marijuana in this city?

Mr. BAUM. Well, I thank you, Congresswoman, for the question. I have to say, I'm a Federal official. Marijuana is a Schedule I illegal substance in the country.

Ms. NORTON. And I understand that, and I have very limited time. I'm trying to find cause and effect.

You've seen what's happened in the other eight States. And I'm simply asking, if you make it legal, if everybody is using it anyway, as is surely the case for younger people——

Mr. BAUM. It's not the——

Ms. NORTON. —would that make it less likely that you go to an underground peddler?

Mr. BAUM. Ma'am, respectfully, I don't believe that. It's a harmful substance. Just because it's not killing people the way fentanyl——

Ms. NORTON. I'm talking about how you buy it, sir.

Mr. BAUM. Yeah. Everyone isn't using it, you know. And we have our—I'm concerned about young people in this country and——

Ms. NORTON. All right. Let me ask you this. If you're concerned about young people, would you be concerned that the District of Columbia can't regulate marijuana so as to keep it out of the hands of people under 18, for example? Would that be a concern of yours?

If, in fact, you're going to possess—if a jurisdiction is going to possess marijuana, should it not at least have the opportunity to keep marijuana out of the hands of children?

Mr. BAUM. I worry that making a substance widely available and legal increases acceptance of it and increases use among youth. And I think we need to look very closely at what's happening in Colorado and the other States to see if marijuana use especially——

Ms. NORTON. Can I ask if you are doing that? We would very much like you to do that. What are you doing as to the States that have already legalized marijuana? Are you giving us any feedback so that we'll know what to do when the time comes for reauthorization?

Chairman GOWDY. [Presiding.] The gentlelady's time has expired, but you may answer her question.

Mr. BAUM. We did have a Federal team go out to Colorado and talk to officials across the spectrum, and we're trying to learn about what's happening. I have to say, I'm concerned about this commercialized model of widespread availability of marijuana and very limited controls of marijuana being grown on public lands, of the involvement of cartels in Colorado in some of the marijuana production.

I think there are a lot of challenges, and I think it's something we need to really think about whether we want to make a substance that is harmful more available to our citizens.

Ms. NORTON. Thank you, Mr. Chairman.

Chairman GOWDY. The gentlelady yields back.

The gentleman from Montana is recognized.

Mr. GIANFORTE. Thank you, Mr. Chairman.

And thank you for the panel for your testimony. This is a critically important issue.

And, Mr. and Mrs. Flattery, thank you for putting a personal face on this epidemic we have here.

As I travel, you know, I hear repeatedly the impact of drug addiction on skyrocketing kids in foster care, crime, domestic violence. As I talk to law enforcement, there are so many—in addition to the personal tragedies that we've heard today, so this is very appropriate we have this conversation. And I also am looking for solutions and seek your advice.

I would be curious—we have 50 States where we look at solutions. I'm curious to hear from the panel of any particular examples where States have taken action that have had positive impact on this issue, and just so that we can learn to look at whether or not some of those things make sense at a national level.

Mr. HUMPHREYS. Thank you, Congressman. I'll give you two State policies that show evidence of good effect.

One is, which has been done in Oklahoma, is called reimbursement lock-in. And what this is, is that if you are covered by an insurance program and you have three, four, five, six, seven providers writing you prescriptions, the insurer, say Medicaid, will tell you, look, you can get this prescription, but you have only one doctor. And if that person is doctor shopping or dealing on the side, then they're constrained. But if they're a legitimate paying patient, they still have one doctor. So that's reimbursement lock-in.

Second one are prescription drug monitoring programs. These vary in quality around the country. Some are easy to use, some are hard to use, but the best ones allow a physician to know, before they write that prescription, is this person getting lots of prescriptions other places. It also can be used by the State to see, is there a particular provider who has really suspicious prescribing? When those programs are well resourced, they reduce overdose deaths. Those should both be used everywhere in my——

Mr. GIANFORTE. So in that particular case, in Oklahoma, how is that actually accomplished?

Mr. HUMPHREYS. It's done through Medicaid. So the Medicaid set up a rule, which they have the power to do as a payer, and said, you know, if you get multiple opioid prescriptions from different providers on Medicaid, you have to pick—one of those doctors is going to be your doctor, period. And they're all going to have to come there. And it's an administrative decision that a Medicaid director can make.

Mr. GIANFORTE. Okay. And open it up to the rest of the panel. Are there other examples you've seen in States that have been effective?

Mr. BAUM. Thank you, Congressman. And I hope to be coming out to Montana. Senator Daines invited us out there, so hopefully——

Mr. GIANFORTE. You're welcome. We have room for you.

Mr. BAUM. So I did want to just mention, you know, police and law enforcement around this country, they really understand this problem very well. And they've been innovating across this country, especially in the States that are hard hit. And I think that sometimes we oversimplify. But, you know, there are drug traffickers, drug dealers, and major violent criminals, and those people need to go to prison for their crimes. But there are also people that their only offense is using and purchasing drugs, and many of those people can be diverted to treatment.

And there's a lot of innovation. I mentioned in my testimony the police-assisted addiction program where police are actually taking people in, opening up their police station 24 hours. If you want to come in for treatment and you don't have any serious trafficking or criminal offense, they will do a—an interview with them and consult with a health worker, and they'll put them in the car and drive them right to treatment.

And I think—you know, police are very smart and flexible, and getting the people in the treatment who need treatment is something that they are facilitating across the country. Fire departments are doing it as well.

You know, you look at the people in our communities that operate 24 hours a day, police, fire, crisis intervention, they are really stepping up and are a critical part of the solution all across the country.

Mr. GIANFORTE. And, Mr. Baum, where is that particular program being run?

Mr. BAUM. Yeah. It started in western Massachusetts, and my office could give you more information, but now it's in 250 places all across the country. Tremendous leadership by police chiefs and sheriffs who are stepping up to deal with this problem.

Mr. GIANFORTE. Okay.

Ms. MAURER. Just real quickly to echo what Mr. Baum was just discussing, that was one of the main themes of the comptroller general's panel last year, was the real importance of having these community networks at the local level that bring together law enforcement, they bring together public health, they bring together the education sector—our work last year was focused on prevention—but can have real benefits across the board with all different aspects of the illicit drug problems.

Mr. GIANFORTE. Okay.

Mr. FLATTERY. If I may, to sort of add on to the notion that we need to continue to support diversion to treatment in lieu of incarceration, one of the barriers to being effective in doing that is we need a Nation's reengineered treatment system. You cannot divert someone to treatment if in rural areas of many States there is no effective treatment to divert them to. It's an unnecessary and excessive burden to place on law enforcement. And there are a number of noteworthy programs around the country to pursue that, but until and unless we reengineer our treatment system, we're only going to have minimal effect.

And then another follow-on, you had asked, and Mr. Humphreys pointed out, a number of places where we're having some impact on less in prescribing, the original development of voluntary opioid-prescribing guidelines for chronic pain that CDC developed are being mimicked and adopted in the States. The regulation of medicine occurs at the State, not here in this panel, and we are seeing a number of States try and expand the use of prescribing guidelines throughout the practice of medicine in their States, and not only in just ER settings, and that's where they first started, we need them to be applied in general practice settings where 60 percent of opioid drugs are being prescribed.

Mr. GIANFORTE. Thank you. Thank you, Mr. Flattery.

And I yield back.

Chairman GOWDY. The gentleman yields back.

The gentleman from Missouri is recognized.

Mr. CLAY. Thank you, Mr. Chairman.

And I thank the witnesses also for participating in this hearing today.

On May 10, 2017, Attorney General Jeff Sessions issued a memorandum instructing Federal prosecutors to, quote, charge and pursue the most serious, readily provable offense, including mandatory minimum sentences, for drug crimes.

The Sessions sentencing memo marked a reversal from Attorney General Eric Holder's Smart on Crime initiative, which sought to move away from mandatory minimum drug sentences and, instead, focus Federal resources on the most dangerous criminals in complex cases.

AG Sessions appears to be trying to reinstate the harsh and indiscriminate use of mandatory minimum from the failed war on drugs.

Dr. Humphreys, do you think that a strict mandatory minimum policy will help us make progress in curbing the destruction caused by the opioid crisis?

Mr. HUMPHREYS. Thank you for that question, Congressman. I do not think that's the case. What I—I work a lot with States. I travel a lot. And what I see all around the country, South Carolina, Texas, South Dakota, California, Utah, is bipartisan coalition to move away from mass incarceration in the way we handled drug problems, basically, in the 1980s and 1990s.

And the one place that hasn't sunk in as a perspective, I think, is actually in Washington. I think the States are out front on that. There's strong bipartisan agreement. It's better to treat people than lock them up.

You know, there are some horrible actors out there who are doing terrible things, but they are a small part of who gets swept up, generally, in drug enforcement, and we should actually, as acting Director Baum said, be trying to, you know, restore everyone we can. Many of these people are just low-level people who are addicted, and they're much better handled in the health system, not by giving them a, you know, 10-year stint in a prison.

Mr. CLAY. Yeah. And in response to Mr. Sessions' memorandum, Republican Senator Rand Paul wrote, and I quote, "The AG's new guidelines, a reversal of a policy that was working, will accentuate the injustice in our criminal justice system. We should be treating our Nation's drug epidemic for what it is: a public health crisis, not an excuse to send people to prison and turn a mistake into a tragedy."

Dr. Humphreys, do you agree with Senator Paul?

Mr. HUMPHREYS. I do agree with the Senator that this is a public health—addiction is a public health crisis. And it is, as has been said by Mr. Flattery, a—it is a chronic medical illness. We should be taking care of it in the treatment system.

And, again, I understand that there are terrible drug traffickers who are violent and terrorize communities, and I have no sympathy for them at all. But a huge number of people at the low end of the drug trade are people who themselves have drug problems, and we should be looking at them as people we can try to restore through the treatment system or through collaboration, drug courts being an excellent model. There are other models of probation with what the criminal justice is trying to do is not punish people forever, put them away in a cell forever, but instead, try to restore them to health by working with the treatment system.

Mr. CLAY. Mr. Baum, is your philosophy in line with what we just heard from Mr. Humphreys?

Mr. BAUM. Well, the way I would put it, Congressman, is that every case is different. And in the Federal system, we see primarily significant drug traffickers and the violent criminals. And if you're a significant drug trafficker or a violent criminal, you run a network that's bringing illicit narcotics into our country, breaking our laws, and putting the health of our citizens at risk, I think you do deserve a significant sentence. But I also agree that we need to sort carefully the people that come into the system. And there are many people whose only offense is buying and using drugs. And those people that are drug dependent and not involved in running significant trafficking organizations, those people absolutely should be diverted into treatment, into drug courts, into alternative sentences.

So I think that sometimes folks lose track that the Federal system is really charged with the trafficking issues, the major criminal groups. It's really State and local governments that are responsible for dealing with local drug dealing and drug users that may commit mild/minor offenses. So we really have to learn to tell the difference and treat differently those with different criminal records and criminal backgrounds.

Mr. CLAY. I thank you for your response.

And I yield back, Mr. Chairman.

Chairman GOWDY. The gentleman yields back.

The gentleman from Wisconsin.

Mr. GROTHMAN. Thank you.

It's been a while since I traveled outside the country, I think about 14 years. But the last time I went outside the country, I went to Taiwan, and they don't seem to have this huge drug problem that we do in this country. And at least in my State, I believe, I might be wrong, but I believe more people die of opiate abuse every year than murders and car accidents combined. Certainly, in most counties that's true. It's just horrible.

Are any of you familiar with the type of sentencing that we have in countries which don't have these—like Taiwan, that don't have these huge numbers of people dying from opiate abuse?

Mr. Baum, do you know what they do in other countries?

Mr. BAUM. Yeah. I think, you know, because of the incredible overprescribing we've had in this country for two decades, our problem is like no other. Canada is experiencing some of the similar problems that we have, but there's no other country that hands out these dangerous, addictive narcotic analgesics the way we do.

Mr. GROTHMAN. There's no question. For years—I'll have to write books about the horrible things our medical professionals did the last 15 years. I'm told it's getting better. But does anybody know, if you are caught with enough heroin, that you're caught with heroin in other countries that don't have these problems, what type of prison sentences are handed out?

Mr. BAUM. The nations in Asia tend to have very strict penalties and also very strong messaging about drug use. The U.S. problem is different. And I would simply say, in the U.S., we need to get back, there's a lot we need to do on the prescription drug problem but also on prevention, because we need to get a very strong and consistent message out to our youth about the incredible risk they face when using drugs. Especially with fentanyl contaminating our drug supply, drug use is a very risky behavior, and we really need to prevent and delay—delay and prevent, if we can, initiation of drug use, especially for people, our young people, where they're still growing, their body is still growing. It's very risky behavior for young people.

Mr. GROTHMAN. Okay. We have four people here. Does anybody know what type of drug sentences are handed out in countries like Taiwan that don't have an opiate—big opiate problem? Nobody knows? Nobody has checked into this?

Mr. HUMPHREYS. I have certainly been to Taiwan and other countries like it. They have very, very tough criminal justice sentencing.

Mr. GROTHMAN. Well, both you and Mr. Baum said it's very, very tough. What does very, very tough mean? If you——

Mr. HUMPHREYS. The death penalty for dealers, even for low-level dealers. There's places where even with possession, a small amount of possession, you can end up doing a really long time in prison. But, of course, we have put an awful lot of people in prison in this country. It's not as if we haven't tried that route. And I think we are different than those more cohesive, smaller societies, more freedom-loving society, a more capitalistic society, and also a healthcare system that is out of control on the prescriptions.

Mr. GROTHMAN. I'm against capital punishment across the board. But just interesting how other countries deal with it.

Mr. Humphreys, are all people who use opiates or maybe wind up dying of opiates, are they all addicts?

Mr. HUMPHREYS. No, sir, they are not. These are valuable medications, when used properly and safely, that people use them, benefit from them, and then do not get addicted. It is not everybody.

Mr. GROTHMAN. What percentage of people who die of opiate abuse do you think are addicts?

Mr. HUMPHREYS. Of the people who die of abuse, I would say most of them are. There's occasionally people who have essentially, if I can say, like an accidental exposure, like a kid goes to a party and gets an Oxy they've never had before, has it with a lot of alcohol and dies. But most of the people who are showing up in overdose statistics have been using for awhile and are addicted.

Mr. GROTHMAN. I'll tell you what goes on in my area, and I'd like you to comment on it. In my area, we are told that the opiates are frequently purchased from a dealer in Milwaukee County, and then the opiates are brought back to Fond du Lac County or Ozaukee County or more rural points north. And the thing that frustrates local law enforcement is they feel, because Milwaukee County is kind of a liberal county, that, well, if they—if people are caught selling drugs in these more northern counties where there are, you know, a little stricter judges, they are strongly deterred from selling drugs again. But in Milwaukee County and more liberal counties, they get a slap on the wrist. And I was under the impression that maybe if we forced liberal counties to put mandatory minimums on, maybe it would deter some of these sellers that right now only get a slap on the wrist. Would you comment on that?

Mr. HUMPHREYS. Yeah. I mean, low-level dealers and many people who have drug problems——

Mr. GROTHMAN. Not necessarily low level, but go ahead.

Mr. HUMPHREYS. Okay. Yeah. I'd be happy to talk to you at length more than we have time here for, Congressman, but I don't believe that the really long sentences motivate that population because they don't think that way. They're not thinking about what they're going to do in 11 years. They're thinking pretty close. And so I don't think when you threaten from 10 to 20, that that motivates them. That's what I've seen.

Mr. GROTHMAN. I think that's an insulting thing to say, but I've gone over my time.

Chairman GOWDY. The gentleman yields back.

The gentleman from Massachusetts is recognized.

Mr. LYNCH. Thank you, Mr. Chairman, and thank you and the ranking member for holding this important hearing. And I want to thank the members in the panel for helping the committee with its work.

Director Baum, back in 1993 till about 2009, your position as director, even though you're acting director, Director of the Office of National Drug Control Policy was a Cabinet-level position. I have joined with Mr. Rothfus and a large group of Democrats and Republicans writing to President Trump asking him to reestablish the Director of the Office of National Drug Control Policy as a Cabinet-level position.

Could you tell the committee what that might mean if we were to reelevate that position?

Mr. BAUM. Thank you, Congressman, for the question. You know, in my service at ONDCP, both under the Bill Clinton administration and the George W. Bush administration, I watched Barry McCaffrey and John Walters operate. And I see that being in the Cabinet, being at the Cabinet meetings, and being able to engage as an equal with the other Secretaries was something that's valuable.

I have to say, in the Trump administration, I've had strong support from the Cabinet. I've met with the Cabinet Secretaries and engaged with them frequently. So that political support is very strong in the Trump administration.

But I do understand your point that it can be an asset to be formally included in the President's Cabinet.

Mr. LYNCH. Right. I want to go back to the marijuana question. So in my State, by referendum, the citizens of Massachusetts just voted to approve of recreational marijuana in my State. Now, my personal experience has been—I opposed to that, but we lost decisively on the ballot question. I just cannot see how flooding the streets with another drug is going to help.

And part of my work as a Member of Congress has been to establish a residential treatment facility for young people, because the age at which these young people have been lured into OxyContin and then heroin and fentanyl is just—it's a horrific situation. And I've got probably 500—500 kids that have died of a drug overdose.

And, Mr. Flattery, I'm totally sorry for your loss, and I certainly empathize with your position, and I'm thankful for your courage to come forward, you and your wife, with your son's situation.

But I could find no really decisive studies on the effects of marijuana on the developing brain. You know, and obviously, when you—when you put something out—when you legalize recreational marijuana, society is putting this imprimatur of acceptance and implied suitability so that people are going to look like, hey, this is something that's not harmful, and I can engage in that.

Can you talk a little bit about what that might mean for the general population?

Mr. BAUM. Thank you, Congressman. Let me say a few words, and then maybe Dr. Humphreys has a few words as well. You know, States have a lot of options in how they manage something like marijuana. And I think sometimes that we're looking at this sort of all-in-or-all-out kind of policy. And if States want to alter and have a less severe sentencing——

Mr. LYNCH. And I totally support that. Believe me, I don't think people should be thrown in jail for smoking marijuana. That doesn't happen.

Mr. BAUM. And that's my point. So States have options, but the idea that it's going to be so legal and so accessible to young people really does put themselves at risk.

And, you know, there's a lot of research already on the harmful effects, physical and cognitive, caused by marijuana. And this research was done on earlier marijuana before we had these incredible high levels of THC, which we have now. The new forms of marijuana, shatter and wax and the liquids that are being vaped, these are very, very powerful substances. The super powered marijuana has not been tested.

So I just—you know, as a parent, I just don't want my kids and other kids in this country at a young age being exposed to these substances. And I think we really got to think about, when we make these policy decisions, what's best for your youth.

Mr. LYNCH. Mr. Humphreys, you want to add? Dr. Humphreys?

Mr. HUMPHREYS. Yes, sir, I would. Marijuana is way more potent than it's been in previous eras, and people are using it every single day much more. So I'm quite worried about the public health impact. I think it's being underestimated how destructive this drug can be.

And I'm also worried about the fact we're having a commercial industry promoting the product with very little regulation. It's kind of like tobacco industry's fantasy of what they always wanted, the marijuana industry is getting. I think the regulatory framework in these States needs to be much, much stronger, otherwise we're going to regret it deeply.

Mr. LYNCH. Thank you.

I yield back, Mr. Chairman.

Chairman GOWDY. The gentleman from Massachusetts yields back.

The gentlelady from Florida is recognized.

Mrs. DEMINGS. Thank you so much, Mr. Chairman. Thank you for this very important hearing today.

And thank you as well to our witnesses, particularly Mr. and Mrs. Flattery. We thank you for introducing us to Kevin today.

As a former police chief, we in Florida are all too familiar with the devastation drug addiction inflicts on families and on every community it touches. First, we battle pill mills and—but now we see ourselves—last year, we lost 14 persons a day, higher than even during the height of the pill mill crisis. In Orange County, the sheriff's office responded to more than 160 overdoses in the first 3 months of this year. Is this an epidemic? I would say yes, it is.

Too often, the criminal justice system, as we've heard many times today, serves as the initial stop for individuals suffering from addiction disease. The Orange County jail has become the de facto and is called the largest drug treatment center and mental health provider in the region.

In the Obama administration, we saw a shift to a public health model of response to the opioid epidemic and an increase focused on prevention, treatment, and recovery efforts.

Dr. Humphreys, can you just give us some examples of prevention treatment and recovery efforts that were expanded under the Obama administration and why these efforts are so important in fighting the drug addiction crisis?

Mr. HUMPHREYS. Thank you for that question. I'd be very happy to do so. We saw addiction as a health problem, and, therefore, we tried to build health services directly into the mainstream healthcare system.

Historically, addiction treatment has been funded by, you know, a separate block grant away from all of medicine. That makes the services uncoordinated. It makes them hard to access. So that is why—wanting to break away from that is why the Affordable Care Act says that taking care of substance abuse disorders is an essential healthcare benefit. You go to the same healthcare system. It's reimbursed the same way. It makes it easier for people to access. They don't feel as stigmatized. They can talk to their regular doctor, and the doctor can get paid for intervening with it.

Same thing in the Medicaid expansion. Covering substance abuse disorder as a core service, not an add-on, not a blocker, and not a special set aside, but a core service. Because, you know, this is a problem that is very prevalent among Medicaid enrollees. It's a health problem that needs to be addressed, and so we try to build everything in.

And if we do that in Washington, our belief, and my belief, was that that makes it much more likely on the ground in your community and everyone else's community that the locals will work together too. They'll know who each other are and they'll work together to bring people back to health.

Mrs. DEMINGS. Thank you so much.

And, Mr. Flattery, earlier, we were talking about some of the creativity from local jurisdictions, and you mentioned one of the barriers to that is just the need to reengineer, I believe you said, treatment programs. I think we ran out of time. I'd love to hear a little bit more of your thoughts on that.

Mr. FLATTERY. Well, I believe that the treatment, the world of treatment, especially for opioid substance use disorder is entirely broken. In many rural areas of the country, there is no treatment at all. In those counties, particularly in my newly adopted State that have some treatment, there are limits. There are cost issues. There are insurance coverage issues. There's actual stigma from those in recovery who are judging others who are choosing medication-assisted treatment. There are prescribers who are charging cash on the barrelhead only and sometimes $500 to treat someone with buprenorphine.

There are manufacturers of alternative medication-assisted treatment who are in every State capital lobbying and making statements about competitor medication-assisted treatment. All of those are creating barriers to people getting evidence-based treatment.

And I previously had discussed some 30-day residential treatment programs who, I believe, are often treating people as customers and not patients, and they're detoxing and releasing people to the wild in a short-burst attempt. A 30-day attempt is woefully inadequate when we're dealing with a chronic long-term condition.

So that's kind of what I—those are—there are a number of issues surrounding why our treatment system just does not work, and we need—we need to reengineer it with some of the enthusiasm that we're using today to discuss changing our Nation's healthcare system.

Mrs. DEMINGS. All right. Thank you so very much.

Mr. Chairman, I yield back.

Chairman GOWDY. The gentlelady yields back.

The gentlelady from the Virgin Islands is recognized.

Ms. PLASKETT. Thank you, Mr. Chairman, and thank you for holding this hearing.

The High Intensity Drug Trafficking Area program, or HIDTA, was created to provide assistance to Federal, State, local, and Tribal law enforcement agencies operating in areas determined to be critical drug trafficking regions in the United States. There are currently 28 HIDTA regions, which include almost 66 percent of the U.S. population in 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. To date, these regional HIDTAs have steadfastly worked with local law enforcement to coordinate efforts and share intelligence.

Mr. Baum, do you consider the work of HIDTA integral to the advancement of the mission of the Office of National Drug Control Policy?

Mr. BAUM. Thank you, Congresswoman, for the question. We are extremely proud of the HIDTA program. They are working every day in a partnership, Federal, State, local, collaborating on looking at and studying the problem they face in each of these regions and deciding together on the priorities.

I think it's important to make the point that ONDCP, we provide grants for the programs, but we don't tell them what to focus on.

Ms. PLASKETT. Right.

Mr. BAUM. It's a regionally focused program, and it's designed to bring people together and coordinate Federal, State, and local law enforcements, and they're producing very dramatic results. Actually, if you look at the amount of cash and assets they're seizing, they more than pay for themselves three times over, 3–1/2 times over.

So I thank the Congress for their great support of the HIDTA program. It's really getting a great return on the dollar. They are really making a difference in our communities.

Ms. PLASKETT. As you talked about success, HIDTA initiatives identified over 8,800 drug trafficking organizations, disrupting or dismantling over 2,700 of them, and seizing over $895 million in cash and noncash assets from drug traffickers in 2015. And as you said, these were organizations working with local law enforcement who identify the threats specific to those areas, identify how to go after them, how to disrupt and to dismantle those activities in the areas in which they are working.

I've seen the work that they're doing in the Virgin Islands. And as a former narcotics prosector, I'm just completely very—however I can be supportive of the work that they're doing in those areas is really important.

But in the area in which I represent the U.S. Virgin Islands, and Puerto Rico, where HIDTA works together, they cover—that area

is recognized by ONDCP in 2013 for its outstanding work in disrupting drug trafficking networks through the Caribbean destined for the mainland USA.

Mr. Baum, would you agree that the HIDTA region that covers the U.S. Virgin Islands and Puerto Rico is integral to combating transit routes for drugs from South America into the U.S. mainland?

Mr. BAUM. Yes, absolutely, Congressman. It's a very important area, and it is sort of in the neighborhood of the world that faces a lot of drug challenges, and so we're very pleased to have the HIDTA there, and we know it's a significant threat that you face in the Virgin Islands.

Ms. PLASKETT. Yes. You know, we are—right now, the U.S. Virgin Islands, according to the FBI in 2016, has the highest murder rate per capita in the country, higher than any other State, commonwealth, or territory. And we know that most of it is due to drug trafficking. Most of the drugs are not used by Virgin Islanders. The Virgin Islands was purchased because of our geographic importance, and drug dealers are smart people. They recognize that there's an important route there as well and are using the islands for that.

Nonetheless, the House today will likely appropriate over $1–1/2 billion to begin building a wall on our southern border, and meanwhile, the Virgin Islands and places like me are facing enormous murder rates, enormous disruption to our communities because of this drug trafficking, because of what's happening there. And I believe that a lot of that money, those billions of dollars that are being spent on that wall and appropriated there, could be better used to wall ourself from the drug trafficking that is coming through this country.

Mr. Baum, is there any additional moneys that you think that HIDTA would need to be effective in its war against drugs?

Mr. BAUM. Congresswoman, the President in his fiscal year 2018 budget request asked for $246 million for the HIDTA program. That's the largest request ever from an administration. And so we're hoping to get Congress' support for that.

And on the border security issue, border security is very important. We face a lot of challenges, and so there is a need for infrastructure and officials. And we're really pleased at the incredible leadership of Secretary Kelly in getting CBP and the DHS folks back engaged and combating drugs, so there's a lot that has to be done. Certainly, we think HIDTA is an important part of the drug enforcement solution.

Ms. PLASKETT. Thank you. I just wish Mexico would pay for it instead.

I yield back.

Chairman GOWDY. The gentlelady from the Virgin Islands yields back.

I'll recognize myself for 5 minutes of questioning.

Dr. Humphreys, it is currently against the law to prescribe controlled substances outside the course of a professional medical practice. It's a pretty arcane statute. It's not used all that often. But it strikes me that until you control that group that is uniquely empowered to prescribe controlled substances—and I appreciate the

fact that Director Baum thinks it's an education issue. I don't know that many dumb doctors. I don't know that many—I don't think it's an education issue as much as it is a money issue.

So how do we capture the attention of those uniquely situated people in our culture who have the authority to write controlled substance prescriptions?

Mr. HUMPHREYS. Thank you for that question, Mr. Chairman. I divide doctors up as follows: The biggest group of doctors are good people who do the right thing, and they need to be left alone. The second biggest group are good doctors who do the wrong thing, and they need education and training.

There is a third group. It is a small group. It's probably less than 1 percent of physicians who are not good people, and they do the wrong thing knowingly. And we saw this, my time at ONDCP in Florida, a massive concentration of people giving out huge quantities of OxyContin. And I think at that point, they're no different than any other drug trafficker. The fact that they're an M.D. is irrelevant. They know what they're doing. They're being harmful, and that's why we have law enforcement to go after them, and I'm all for them doing that.

Chairman GOWDY. Well, I know we do, and we certainly used to. It was phentermine and fenfluramine back when I was at the DA's office, but DA diversion is not as active. Unless you know something I don't know, they're not as active as they once were. So I get that it's hard to go after doctors.

And just so the record's clear, my dad's a physician. I actually like doctors, but they are uniquely empowered in our culture. Gerry Connolly can't write a prescription for an antibiotic or a controlled substance. Doctors can. And you can be in this specialty but write an analgesic prescription.

So I'm with you. I appreciate the deference you show to physicians that it's an education, and I do think the overwhelming majority want to do the right thing for the right reasons. But there's a lot of money in this particular realm. And until there are prosecutions for physicians who prescribe outside the course of a professional medical—and what I mean by that, just so nobody thinks I'm getting too complicated, writing a prescription on a cocktail napkin at a bar for someone you just met that you've never done any diagnostic test on, you just happen to take his or her word, I like my chances in front of a jury of that being outside the course of a professional medical practice.

So, Mr. Baum, as you write your plan, it'd be great if you could address DEA diversion and whether or not they're being plussed up. I know it's tough to go after doctors. Juries are sympathetic with them, but they are uniquely positioned in our culture, and somehow or another we've got to address it.

Dr. Humphreys, let me ask you this: You mentioned drug court a couple of times. Do you have a position or is there research that indicates whether preadjudication drug courts or postadjudication drug courts work better?

Mr. HUMPHREYS. I'm not aware of research that proves that point, because those populations are really different kinds of people, typically, the people who are given the option early versus later. I do know that both—both drug courts as well as other mod-

els that have been promulgated, HOPE Probation is one that now the Federal Government supports, 24/7 Sobriety on the alcohol side where you use the court as a mechanism to enforce abstinence with regular checks and treatment backup as needed all show, you know, very good outcomes. We should be doing those much more. By good outcomes I mean you get the trifecta, the public is safer as the person is held accountable, substance abuse goes down, and then incarceration goes down.

Chairman GOWDY. Well, I want you to help me with something, if you can. And I ask this respectfully. As you travel, if you're ever invited to address a group of public defenders or criminal defense attorneys, oftentimes they will refuse the offer of drug court because probation is easier. It is not better for their client, but it's easier. So we've got to kind of reconfigure what is in the best interest of the client. Remaining addicted but just having a shorter period of probation is not in the best interest of the client, and they'll believe you and they won't believe an old prosecutor.

So in my remaining time, Director Baum, in case my mom is watching, I want to be really clear, I'm not advocating for the legalization of marijuana. I want to be very, very clear about that. However, I don't understand why it's a Schedule I. It's certainly not treated as an inherently dangerous substance for which there is no medicinal value. It takes a tractor-trailer full of marijuana to even trigger a mandatory minimum under our drug laws.

So is there any appetite for researching whether or not it should remain a Schedule I drug?

Mr. BAUM. Congressman, the administration doesn't have a position on that, but I'm happy to dialogue with your office. And let me just briefly say that we strongly support research on medical use of marijuana. And if there are obstacles that we see that prevent good research, we want to address those obstacles. Because if there are component elements of marijuana that could be put through the FDA process and turn into medicines that could help people in this country, we want to do that. So we do think there's a potential and we support research on the subject.

Chairman GOWDY. Well, just so everyone's clear, methamphetamine is schedule what?

Mr. BAUM. I believe it's Schedule II.

Chairman GOWDY. Cocaine is schedule what?

Mr. BAUM. Also II.

Chairman GOWDY. Cocaine base is schedule what?

Mr. BAUM. A——

Chairman GOWDY. II. So it is scheduled lower than marijuana. And, again, you can schedule something and still not have it scheduled as a I? And I would encourage the powers that be, whoever you need to consult with in the administration, to at least explore whether or not it's scheduled correctly without being perceived as advocating for legalization.

Mr. BAUM. Understood.

Chairman GOWDY. With that, Mr. Connolly, I want to give you a chance to—I'm reluctant to say whatever you want, but I'm going to give you a chance to conclude.

Mr. CONNOLLY. Well, I thank my friend. And I actually want to follow up, if I may, on what you just asked.

So the point being made here in some ways, Mr. Baum, is if you—not you personally. If the government, Federal Government, on this subject, marijuana and how dangerous it is, has no credibility because of the lack of serious empirical work, it threatens our whole drug policy's credibility. And you have seen this happen in marijuana in the States. They're making decisions. Ms. Norton talked about eight States, but there are over 25 States that have in some fashion, including my home State of Virginia, liberalized their laws for medical reasons all the way to recreational reasons.

I think you'd have to confess to the chairman's point, there was no empirical evidence to justify putting marijuana 50 years ago as a Schedule I drug. Who did that empirical evidence?

Mr. BAUM. Sir, could you repeat that? Who did what? Who made it schedule——

Mr. CONNOLLY. There was no—I am asserting, and you can feel free to try to contradict, there was, in fact, no empirical evidence to justify putting marijuana ahead of the drugs the chairman just listed as a Schedule I drug 50 years ago. And I would—you brought up the need to have empirical research before we start rushing pill mill to approve it for medical purposes, and I agree with you. But here's the problem: As I said in my opening statement, only one Federal entity, NIDA, controls marijuana for legal purposes for experimentation, testing, and the like, research. And NIDA's mission is all about proving the harms of something. They've priority determined the outcome research. Nobody thinks NIDA is an objective neutral place to go to look at the good, the bad, and the indifferent about marijuana. It doesn't have that credibility.

So if we're going to do what you suggest, we need to have a different entity with credibility where we're looking at objective evidence and science, and then we can determine, well, where does marijuana work?

Mr. Humphreys made the point that there's a more lethal or stronger, more fortified versions of marijuana coming out that concern us. But we put a lot of people in jail, and we've treated this like it's more dangerous than cocaine and the other substances the chairman—and it's had huge consequences based on very little scientific evidence.

I'm not arguing for the legalization either. I agree with my friend from South Carolina, I'm not going there, but neither can I justify the current policy of treating it as the world's most dangerous drug with this classification.

You can feel free to respond, and I'm done.

Mr. BAUM. Congressman, I understand the point that you're making. I would love to go with you in your district to talk to police—police chiefs and sheriffs. I think in reality, on the street, police, sheriffs, they don't treat marijuana the way they treat heroin and fentanyl. So I think in practice, there is a prioritization of the most deadly drug threats.

Chairman GOWDY. I think—I actually think that's his point, is that law enforcement doesn't, our sentencing scheme does not. Methamphetamine and marijuana are not treated the same from a sentencing standpoint, but yet marijuana is considered to be inherently dangerous with no medicinal value, therefore, a Schedule I.

And it would just be helpful, again, to Mr. Connolly's point, for us to have some consistency, or at least be able to explain why certain drugs are Schedule I and others are not. And, you know, we can save that for another day. And, again, that's coming from two people that are not advocating for the legalization, just for some common sense in how it's scheduled.

On behalf of all the members, I want to thank all of our witnesses for your expertise.

Mr. and Mrs. Flattery, in your case, your very tragically earned expertise in this area. And I cannot imagine how painful it is. Any and every parent—and you don't have to be a parent to appreciate how difficult what you have done today is. And I salute you for your advocacy so other parents do not have to live through what you and your wife have lived through.

I want to thank all the witnesses for your collegiality with one another and your comity with one another and with the committee.

And with that, if there's no further business—thank you, Mr. Connolly—without objection, the committee stands adjourned.

[Whereupon, at 12:31 p.m., the committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Congress of the United States
Washington, DC 20515

May 16, 2017

The Honorable Mick Mulvaney
Director, Office of Management and Budget
725 17th Street Northwest
Washington, District of Columbia 20503

Dear Director Mulvaney:

We are writing to express our concern about reported severe reductions to the Office of the National Drug Control Policy (ONDCP) in the fiscal 2018 budget that would put in jeopardy programs that provide needed assistance to state and local law enforcement and community coalitions to fight the growing opioid epidemic.

As you know, ONDCP has played a critical role in coordinating the nation's drug control efforts. Since 1988 this office has enjoyed bipartisan support for its mission of protecting public safety and promoting public health. The office's National Drug Control Strategy has provided an important blueprint to guide and coordinate the efforts of federal, state, and local partners to ensure an evidence-based and accountable strategy to address the devastating impact of drugs on our communities.

The need for a coordinated, effective, and accountable approach to substance abuse and drug trafficking is greater than ever. The National Institute of Drug Abuse reports that the number of overdose deaths from prescription opioids increased by a factor of 2.8 between 2002 and 2015. The number of heroin deaths increased by a factor of 6.2 in the same period. This epidemic is being felt in communities throughout the United States and the effects have been devastating.

The High Intensity Drug Trafficking Areas (HIDTA) program, overseen by ONDCP, has been a critical component of the National Drug Control Strategy. This program aids in the coordination of federal, state, and local drug task forces to disrupt or dismantle drug trafficking organizations. It also engages and provides support to state and federal prosecutors to convict individuals associated with drug trafficking organizations. In recent years, HIDTA seizures have yielded billions of dollars that transnational criminal organizations would have used to reinvest in the illegal drug trade. Instead, this cost-effective program has reinvested proceeds in efforts to further address the causes and effects of substance abuse.

The office's Drug Free Communities (DFC) Program has been similarly effective. Its approach to addressing local problems with community-driven solutions has consistently shown reductions in past 30-day use of alcohol, tobacco, and prescription drugs. The program is designed with strict accountability provisions to ensure the highest levels of local support in solving the substance abuse crisis each community faces. By law, there is a cap on the amount of money that can be spent on administrative and overhead expenses, which ensures that the

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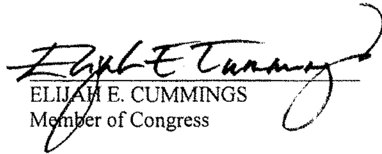
maximum amount of funding goes to DFC coalitions that have the power to reduce youth substance use in their own communities. Coalitions are required to be in existence and fully functioning for a minimum of six months before they are eligible to apply, and they must have baseline data to show that they have full knowledge of local drug issues, as well as matching federal funding with dollar-for-dollar local funds.

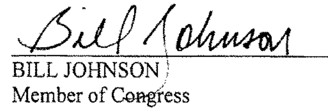
For almost two decades, ONDCP has had a critical role in ensuring the nation's drug policy is effective, accountable, and evidence-based. The Office and the programs it supports are uniquely positioned to address the causes and effects of the current opioid crisis with proven strategies and broad reach. For these important programs to remain effective, we believe they must continue to be funded fully and coordinated effectively. We are gravely concerned that any interruption would exacerbate the crises in our communities and we remain committed in working together to reverse the damaging effects that opioids and other drugs have had on American families.

We respectfully request clarification on the Administration's intended actions to ensure the continuity of HIDTA and DFC and look forward to your response.

Sincerely,



ELIJAH E. CUMMINGS
Member of Congress



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BRIAN K. FITZPATRICK
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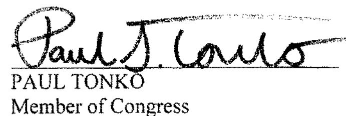
Member of Congress

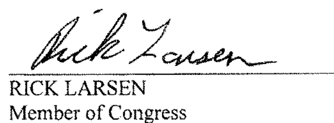
DWIGHT EVANS
Member of Congress

TIM RYAN
Member of Congress


PAUL TONKO
Member of Congress

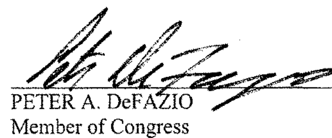
FILEMON VELA
Member of Congress

BRAD R. WENSTRUP
Member of Congress


RICK LARSEN
Member of Congress

DEBBIE DINGELL
Member of Congress

PATRICK MEEHAN
Member of Congress


PETER A. DeFAZIO
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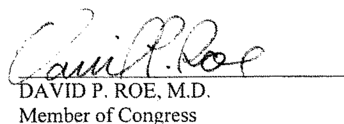
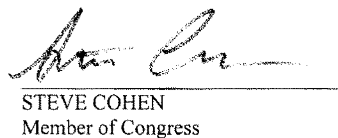

DAVID P. ROE, M.D.
Member of Congress

JOHN J. FASO
Member of Congress

SUZANNE BONAMICI
Member of Congress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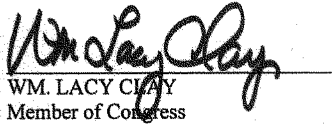
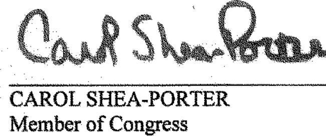

WM. LACY CLAY
Member of Congress


CAROL SHEA-PORTER
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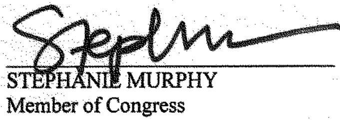
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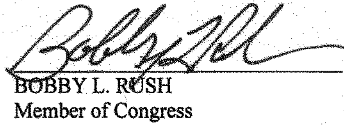
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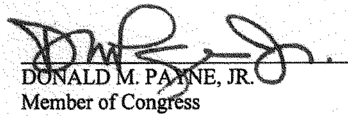
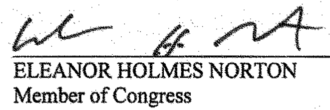
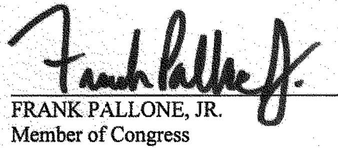
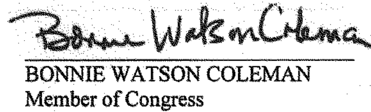
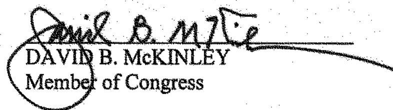

DONALD M. PAYNE, JR.
Member of Congress

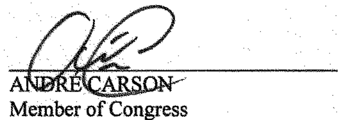

ELEANOR HOLMES NORTON
Member of Congress

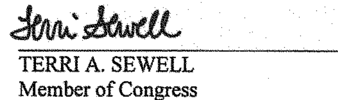

FRANK PALLONE, JR.
Member of Congress

BRENDA L. LAWRENCE
Member of Congress


BONNIE WATSON COLEMAN
Member of Congress


DAVID B. McKINLEY
Member of Congress


ANDRÉ CARSON
Member of Congress


TERRI A. SEWELL
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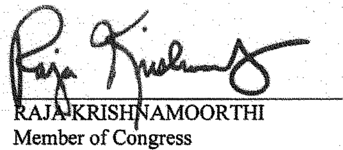
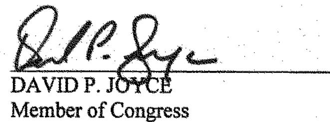
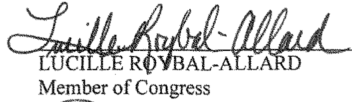
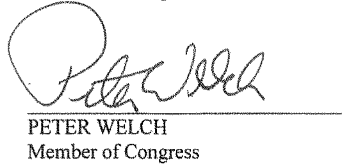

RAJA KRISHNAMOORTHI
Member of Congress


DAVID P. JOYCE
Member of Congress

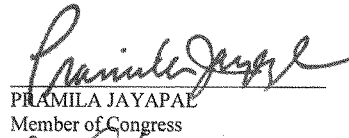

LUCILLE ROYBAL-ALLARD
Member of Congress

DORIS MATSUI
Member of Congress

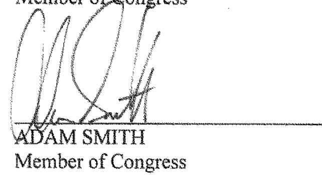

PETER WELCH
Member of Congress

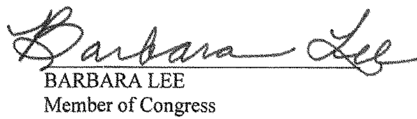
ANTHONY G. BROWN
Member of Congress

STEVE STIVERS
Member of Congress


PRAMILA JAYAPAL
Member of Congress

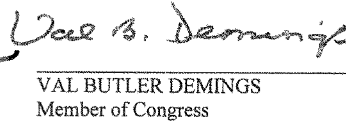
DAVID N. CICILLINE
Member of Congress


ADAM SMITH
Member of Congress

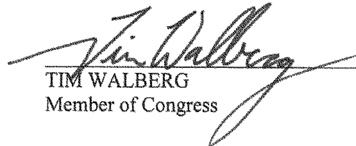

BARBARA LEE
Member of Congress

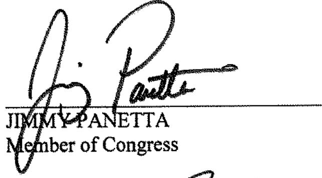
VICENTE GONZALEZ
Member of Congress

MICHELLE LUJAN GRISHAM
Member of Congress


VAL BUTLER DEMINGS
Member of Congress

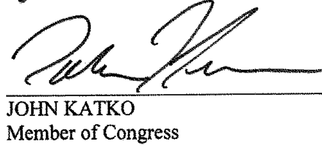
SEAN PATRICK MALONEY
Member of Congress


TIM WALBERG
Member of Congress

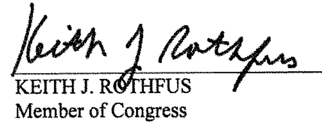


JIMMY PANETTA
Member of Congress

DANIEL M. DONOVAN, JR.
Member of Congress

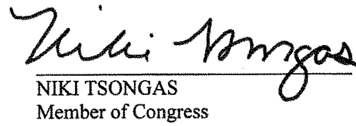


JOHN KATKO
Member of Congress



KEITH J. ROTHFUS
Member of Congress

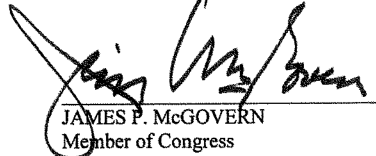
JAMIE RASKIN
Member of Congress



NIKI TSONGAS
Member of Congress

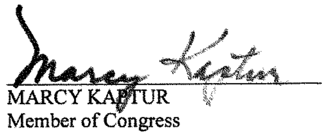
RYAN A. COSTELLO
Member of Congress

JOHN A. YARMUTH
Member of Congress



JAMES P. McGOVERN
Member of Congress

EVAN H. JENKINS
Member of Congress



MARCY KAPTUR
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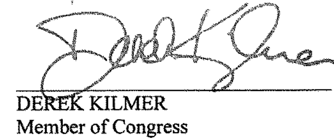

DEREK KILMER
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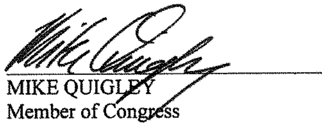
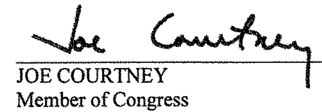
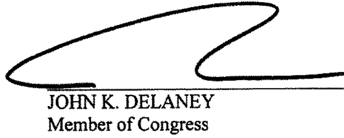
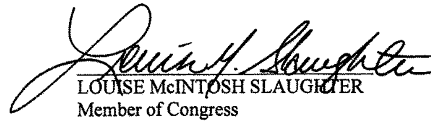


MIKE QUIGLEY
Member of Congress

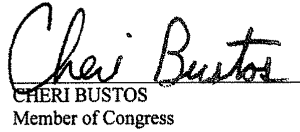


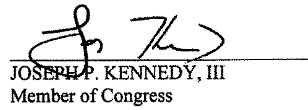
JOE COURTNEY
Member of Congress

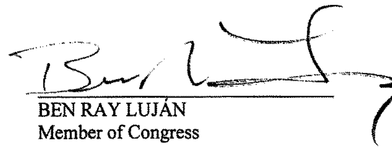

JOHN K. DELANEY
Member of Congress


LOUISE McINTOSH SLAUGHTER
Member of Congress

CHELLIE PINGREE
Member of Congress

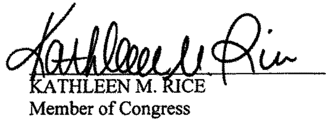

CHERI BUSTOS
Member of Congress


JOSEPH P. KENNEDY, III
Member of Congress


BEN RAY LUJÁN
Member of Congress

ANN McLANE KUSTER
Member of Congress

A. DONALD McEACHIN
Member of Congress


KATHLEEN M. RICE
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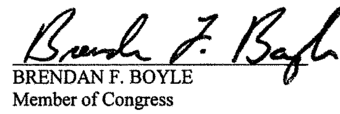
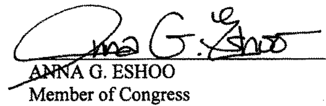
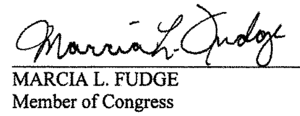

BRENDAN F. BOYLE
Member of Congress


ANNA G. ESHOO
Member of Congress

DAVID SCOTT
Member of Congress

LINDA T. SÁNCHEZ
Member of Congress


MARCIA L. FUDGE
Member of Congress