AMERICA'S GROWING HEROIN EPIDEMIC

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, HOMELAND SECURITY, AND INVESTIGATIONS

OF THE

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JULY 28, 2015

AMERICA'S GROWING HEROIN EPIDEMIC

TUESDAY, JULY 28, 2015

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON CRIME, TERRORISM,
HOMELAND SECURITY, AND INVESTIGATIONS

COMMITTEE ON THE JUDICIARY

Washington, DC.

The Subcommittee met, pursuant to call, at 10:06 a.m., in room 2141, Rayburn Office Building, the Honorable F. James Sensenbrenner, Jr. (Chairman of the Subcommittee) presiding.

Present: Representatives Sensenbrenner, Goodlatte, Gohmert, Chabot, Forbes, Poe, Gowdy, Labrador, Buck, Bishop, and Chu.

Staff present: (Majority) Allison Halataei, Parliamentarian & General Counsel; Robert Parmiter, Counsel; Scott Johnson, Clerk; (Minority) Joe Graupensperger, Counsel; Kurt May, Counsel; Tiffany Joslyn, Counsel; and Veronica Eligan, Professional Staff Member.

Mr. SENSENBRENNER. The Subcommittee will be in order. Without objection, the Chair will be authorized to declare recesses this morning at any time.

We welcome our witnesses today.

Our Nation faces a profound challenge with a growing heroin epidemic. Last year the number of heroin-related deaths in Milwaukee County, Wisconsin, which includes part of my district, grew by a shocking 72 percent, while Superior in Northwestern Wisconsin suffered six overdoses in 6 days this past February. Clearly, this is a problem that does not discriminate by race or class and transcends geography.

Earlier this year, the White House Office of National Drug Control Policy released the 2013 Drug Overdose Mortality Data from the Centers for Disease Control and Prevention. The data shows that while drug deaths related to prescription opioids has remained stable since 2012, the mortality rate associated with heroin increased by 39 percent, by more than triple the levels in 2012. That represents the third year in a row that the number of heroin deaths has increased nationwide.

This past weekend the Washington Post reported the tragic story of a family in Maine that lost a child in nearly a second to heroin laced with phenotil, an opioid analgesic 80 to 100 times more powerful than morphine. Heroin cut with phenotil has been responsible for a rash of overdoses and deaths across the country. Shockingly,

the fact that a particular batch of heroin has killed someone is often what attracts addicts to it because they know it will deliver an extremely potent high.

It is obvious, then, that the solution to this problem must involve appropriate access to treatment, as well as enforcement. That is why earlier this year I introduced H.R. 953, the Comprehensive Addiction and Recovery Act of 2015. This legislation would take a number of important steps to combat the heroin epidemic.

For example, the bill addresses the link between prescription opioids and heroin by requiring the Department of Health and Human Services to convene a task force to develop best practices for pain management and prescribing prescription drugs and share those with the appropriate authorities. The legislation also authorizes grants that provide for alternatives to incarceration for veterans, as well as those individuals with a substance use disorder, mental illness, or both. And finally, it would give priority to awarding grants to those states that provide civil liability protection for first responders, health professionals and family members administrating naloxone to counteract opioid overdoses.

I also have introduced a bipartisan criminal justice reform act, the Safe Justice Act. This legislation promotes drug and substance abuse treatment programs over harsher sentences. We know that approximately 60 percent of prisoners have substance and addiction disorders, yet only 11 percent receive treatment. It is no wonder why recidivism rates are as high as they are. This is not a crisis we can simply incarcerate ourselves out of.

The bill would authorize the use of medication-assisted treatment for the treatment of heroin and opioid dependence in the Bureau of Prisons, residential substance abuse treatment programs.

Finally, the Safe Justice Act would offer training to Federal law enforcement officials to help them better identify and respond to individuals with drug and substance abuse issues. I look forward to hearing from the witnesses today about additional approaches to curb this epidemic.

At this time, I would like to yield to the gentlewomen from California, who is the Ranking Member pro tem of this Subcommittee today, Ms. Chu.

Ms. CHU. Thank you, Mr. Chair.

Today's hearing concerns finding the best means to respond to the increasing use of heroin in this country, which is tragically proving to be more deadly than in the past. Despite the heroic efforts of our Federal law enforcement and the DEA, the volume of heroin coming into this country continues to rise. Every year brings new records in the amounts of drugs seized at our border by interdiction programs. From 2008 to 2012, the DEA noticed a 232 percent increase in heroin seizures along America's Southwest border.

The rate of state and local law enforcement seizures of heroin continue to rise as well. Still, the current level of heroin use indicates that the substance is widely available. It is now cheaper to acquire, and it has no geographical boundaries.

Over 600,000 Americans use heroin, to compound the health risk that this poses. The heroin sold today is more potent and deadlier than ever before. Deaths due to overdose have risen significantly in the last several years. In the last reported year of 2013, 8,257

people died from a heroin overdose. An additional 16,235 died from opioids.

Heroin overdoses in the U.S. have nearly tripled between the years of 2010 and 2013, according to the CDC. Deaths due to heroin overdose now exceed traffic accident deaths in the U.S.

It is time that we acknowledge the fact that we are dealing with a public health care crisis driven by strong demand for opioid drugs.

Where did this great demand come from? Most experts agree that prior to increased use of heroin, millions of Americans became addicted to opioid prescription drugs. The correlation is so strong that experts believe that 80 percent of current heroin users began as abusers of prescription pain killers. To complete this perfect storm, the price of heroin has fallen to new lows, $5 to $10 per day. In comparison, prescription opioids cost about $80 per day.

For those already addicted to an opioid prescription drug, heroin becomes an attractive option. In response, many states are implementing drug treatment programs for those addicted to both prescription drugs and heroin. State reactions include revisiting older forms of treatment such as methadone maintenance, and new approaches including programs for better oversight of prescription medications.

Many police departments across the country are employing the use of the drug naloxone, an antidote to heroin overdose to reduce deaths. There are now hundreds of police departments in 29 states that stock and administer naloxone. Naloxone administered by police is now credited with saving the lives of over 10,000 Americans since 1996. Police departments are also working with prosecutors' offices across the country to create programs to divert users to treatment facilities rather than courts, detention facilities, and prisons. This effort supports a more permanent solution to the health crisis we face. It reduces crime rates and the expenses of incarceration, while allowing courts and police departments to allocate resources in a manner best suited to protecting our citizens.

As we consider proposals to address the increased use of heroin, we would do well to consider the lessons of prior responses to drug abuse. An incarceration-forced approach has not solved this public health crisis. Our focus should be to eliminate impediments to delivering substance abuse treatment to those in need, reduce the harms posed by heroin, and educate our citizens to prevent substance addictions.

I look forward to the discussion of this problem and the best ways that government can help address it. I would like to submit for the record a letter from the Drug Policy Alliance.

Mr. SENSENBRENNER. Without objection, the record will be so embellished.

[The information referred to follows:]

July 28, 2015

The Honorable Jim Sensenbrenner
Chairman
House Judiciary Committee
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations
United States House of Representatives
Washington, D.C. 20515

The Honorable Shelia Jackson Lee
Ranking Member
House Judiciary Committee
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Sensenbrenner and Ranking Member Jackson-Lee:

The Drug Policy Alliance appreciates the opportunity to provide this letter for the record of today's hearing, "America's Growing Heroin Epidemic."

Heroin use and overdose have surged in recent years, and its prevalence has ballooned beyond urban centers into suburban and rural areas. However, attention that is being given today by the media and lawmakers to heroin use and overdose has illuminated a decades old crisis. Until recently, opioid analgesics - a class of prescription drugs such as hydrocodone (Vicodin™), oxycodone (OxyContin™) and methadone used to treat both acute and chronic pain - was fueling much of the nation's overdose epidemic.

Prior to the 1990s, opioid analgesics were prescribed primarily in hospital settings to treat acute pain.[1] Beginning in the early 1990s, however, health practitioners increasingly favored treating chronic pain with opioid analgesics. This shift was an important advancement in pain management, but the change in opioid prescribing habits came without careful attention to misuse and overdose risk.

As long-term prescribing of opioid analgesics for pain became more common, a greater proportion of opioid patients became substance dependent and at higher risk of experiencing an opioid overdose. These conditions contributed to a dramatic rise in opioid overdose fatalities.[2]

By 2007, the CDC reported that opioid analgesics had displaced street drugs as the leading cause of overdose death.[3] By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time. More than 35,000 people died from an accidental drug overdose in 2013, the most recent data available from the CDC.[4] Opioids — both in the form of prescription opioid analgesics and heroin — were involved in most of these deaths. The 2013 figure is nearly double the number of accidental drug overdoses in 2003[5] and more than three times the number of accidental drug overdoses in 2000.[6] Today, urban centers continue to struggle as they have for decades with overdose. However, rural and suburban regions have been disproportionately affected by opioid-related overdoses.[7]

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We are the Drug Policy Alliance.

Interdiction

Federal and state lawmakers have responded to mounting unsanctioned opioid use, dependence and overdose by focusing on supply-side policies intended to reduce diversion of opioid analgesics and other prescription drugs from lawful sources. Most states have passed laws implementing the use of prescription drug monitoring programs (PDMPs) as a tool to monitor prescription sales of controlled substances.[8]

As a health promotion tool, PDMPs enable physicians and pharmacists to review a patient's medication history prior to writing a prescription, which can help a physician avoid medication errors or identify a patient with a pattern of unsanctioned use. However, law enforcement are also given varying levels of authority in each state to monitor PDMPs and launch investigations against health practitioners and patients based upon evidence that, in a law enforcement agency's view, a physician is writing too many prescriptions for opioid analgesics, or a patient is engaging in "doctor shopping."

Prescribing practices by physicians who specialize in pain management and treat patients with chronic pain are often scrutinized by law enforcement for running "pill mills." In turn, law enforcement agencies routinely use PDMP sourced data to raid and shut down clinics that treat chronic pain patients and prosecute physicians for "overprescribing" as well as patients for doctor shopping. PDMPs enjoy broad institutional support, and federal funding,[9] despite underwhelming evidence that they have any impact on overdose rates or unsanctioned use of opioid analgesics.[10]

Moreover, federal survey data indicates that the vast majority of people engaged in unsanctioned use of prescription drugs are not obtaining them from a physician or from engaging in doctor shopping. 53 percent of people who engaged in unsanctioned use of prescription drugs in the past year obtained them for free from friends and family. 15 percent bought or took them from a friend or relative.[11]

Supply-side strategies do not address the underlying behavioral and physical health needs of people experiencing opioid dependence. Tragically, heavy emphasis on supply-side strategies can inadvertently worsen drug misuse in a community if demand-side strategies are not given equal emphasis. Case in point, as law enforcement agencies and lawmakers have stepped up restrictions on opioid analgesic prescribing, evidence suggests that opioid-dependent people who can no longer afford or find diverted medication on the illicit market or a health practitioner willing to prescribe it, are switching to heroin.[12]

From a public health and safety standpoint, heroin use is much riskier than unsanctioned opioid medication use.[13] Whereas pharmaceutical opioids generally deliver a reliable and stable dose, people who turn to the illicit market to obtain and use heroin face a greater overdose risk.[14]

Beginning in 2010, heroin overdose fatalities began increasing rapidly across the country while fatal overdoses involving opioid analgesics began to level off and even declined slightly between 2011 and 2013.[15] Fatalities from heroin overdose nearly tripled from 2010 to 2013.[16] Evidence indicates that a growing number of individuals who have been using opioid analgesics are substituting heroin, and that dependence on opioid analgesic medications is a strong risk factor for heroin dependence.[17]

Law enforcement agencies should not be empowered to decide when a physician has prescribed too much or a patient is being prescribed too many. Too often the assumption is made that a physician is prescribing too much pain medication, an assumption that is often fostered by law enforcement officials and echoed by lawmakers. Prosecuting prescribers believed to be overprescribing certain medications can lead to stigma against patients using those medications, as well as reduced access to certain medications that physicians may be reluctant to prescribe out of fear of law enforcement investigation.[18]

Pain remains one of the most severely undertreated conditions in the U.S. today.[19] As the general population in the United States trends older,[20] and more people are surviving illnesses and undergoing surgical operations, demand for prescription opioid analgesics will likely increase.[21]

Federal and state officials have focused resources on diversion and policing physician prescribing practices with poor results. Opioid use and overdose rates have surged across the nation despite supply-side efforts. In fact, the focus on diversion has likely contributed to this recent surge. In addition, individuals with unmet overdose prevention and treatment needs are also not being served or protected by supply-side strategies.

It is this example that underscores the critical need to turn the nation's discussion about prescription diversion into policies that place much greater emphasis on strategies that more effectively target demand for drug use, enhance and facilitate treatment access, and prevent overdose fatalities. The federal government still focuses the vast majority of its drug-related spending on interdiction, enforcement and incarceration. Billions of dollars are wasted each year on supply-side programs that lack real oversight. Shifting resources from interdiction and incarceration to treatment and public health program funding would save more lives and realize substantial savings for taxpayers.

Prevention

In recent years, the opioid prescribing patterns of physicians have faced greater scrutiny from law enforcement. However, little attention has been given to the duty that health practitioners have to educate their patients about opioid overdose risk. Physicians should be informing patients about proper dosing and overdose risk and prescribing naloxone to patients who are taking opioid analgesics.

Naloxone (Narcan) is a low-cost medication available by prescription and is the first line of treatment for paramedics and emergency room physicians who encounter an opioid overdose victim.[22] Naloxone takes as little as two minutes to start working, and provides additional time to obtain necessary medical assistance during an overdose.[23] Evidence suggest that prompt administration of naloxone and provision of emergency care by a bystander can reduce health complications and attendant health care costs to government and private insurers.[24]

However, naloxone's status as a prescription drug is a key barrier to broader naloxone access in the United States.[25] In an effort to improve the utilization of

naloxone, more than 35 states have passed laws to shield healthcare practitioners and laypersons from civil and criminal liability for prescribing or administering this medication.[26] The Committee should advance federal legislation that provides a national floor of civil liability protections for prescribers and laypersons who administer naloxone in the event of an overdose emergency.[27]

Good Samaritan immunity

Witnesses to an overdose often hesitate to call for help or, in some cases, simply don't make the call. The most common reason people cite for not calling 911 is fear of police involvement and legal consequences.[28] A key way to encourage overdose witnesses to seek medical help is to exempt them from arrest and prosecution. Good Samaritan immunity laws typically protect only the caller and overdose victim from arrest and prosecution for simple drug possession, possession of paraphernalia, and being under the influence. Such legislation does not protect people from arrest for other offenses. Twenty five states and the District of Columbia have passed such laws.[29] The Committee should consider whether federal legislation could extend Good Samaritan immunity to federal lands and territories.

Syringe access

People who inject opioids and other drugs are often stigmatized by health care providers and criminalized by law enforcement. Without reliable access to sterile syringes, individuals are prone to share syringes and other drug preparation equipment with other people who inject drugs. The sharing of syringes is associated with elevated risk of contracting HIV and hepatitis C,[30] and syringe sharing has historically been a major contributor to the HIV/AIDS epidemic in the United States and abroad.[31]

Since the early 1990s, advocates and public health officials in urban centers across the United States have offered syringe exchange services. In addition to providing sterile syringes in exchange for used syringes, many syringe exchange programs provide services such as HIV and hepatitis C testing, overdose prevention training, and serve as a linkage to health care, housing, and drug treatment for those not often served by traditional health care providers.[32] Critically, syringe availability has been proven to reduce the spread of HIV/AIDS and hepatitis C without increasing drug use.[33] Syringe exchange programs are supported by leading United States and international government health organizations and medical and public health associations.[34]

Today, there are more than 190 syringe service programs operating in 33 states.[35] Many jurisdictions have made local investments to support syringe exchange.[36] However, as the opioid crisis has transformed in recent years to include a dramatic increase in heroin use that has shifted from urban centers to rural areas, communities affected in rural parts of the United States often do not have – or even legally permit – the provision of syringe exchange.

These changing demographics have recently taken center stage nationally, with a spike in HIV diagnoses among people who inject drugs in Indiana[37] and with the CDC ranking Kentucky number one in the nation for high rates of hepatitis C cases.[38] Yet, a federal ban prohibiting states and the District of Columbia from using their

share of federal HIV/AIDS prevention money on syringe exchange programs has been in place since 2011.

This ban was briefly lifted by the Democratic-controlled Congress in 2009 after being in place for more than 20 years. Republicans restored the ban in 2011 after regaining control of Congress. Earlier this year, House and Senate Republicans agreed to partially repeal the ban for the first time. However, Congress should completely lift the federal ban and allow state and local governments to spend their share of federal prevention dollars without additional cost to taxpayers. There is little doubt that these congressional bans are responsible for hundreds of thousands of Americans contracting HIV/AIDS or hepatitis C.[39]

Treatment

There is broad consensus among experts that an individual struggling with opioid dependence should have access to the full spectrum of behavioral, pharmacological, and psychosocial treatments. However, nearly 80 percent of people experiencing opioid dependence do not receive treatment because of limited treatment capacity, financial obstacles, social stigma, and other barriers to care.[40] Expanding access to drug treatment is a key strategy to reducing demand for opioid analgesics and heroin. Effective treatment modalities should be available to people at all stages of the recovery spectrum.

Barriers to treatment despite healthcare reform

Barriers to drug treatment persist despite federal healthcare reform. Treatment programs still often fail to meet the needs of populations that have historically confronted barriers to accessing treatment, such as women, people of color, lesbian, gay, bisexual and transgendered (LGBT) individuals, and rural populations. Individuals who use heroin and other opioids are also often both uninsured and marginalized by the healthcare system.[41]

It is critical that people experiencing dependence to opioid analgesics or heroin can enroll in medication assisted treatment. Scientific research has established that medication assisted treatment increases patient retention and decreases drug use, infectious disease transmission, and criminal activity.[42] Medication assisted treatments are cost effective[43] and have been proven equally effective in treating heroin or prescription-type opioid dependence.[44] Opioid dependent individuals should have access to affordable, judgment-free, individualized counseling and pharmacological replacement therapies such as methadone and buprenorphine. Under medication assisted treatment, doctors prescribe one or more pharmaceutical drugs to people with drug-related problems to eliminate or reduce their problematic use of drugs and improve their mental and physical well-being.

At present, the FDA has approved only three medications for the treatment of opioid dependence.[45] Methadone is one of the most widely studied medicines and is employed effectively around the world to treat opioid dependence. Methadone therapy is widely regarded as the most effective treatment for heroin addiction.[46] Methadone and other medication assisted therapies lead to better health and social outcomes than any other treatment modality.[47] The Centers for Disease Control and

Prevention,[48] the Institute of Medicine[49] of the National Institutes of Health,[50] the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services,[51] the National Institute on Drug Abuse (NIDA),[52] the World Health Organization,[53] and over four decades of government-funded, peer-reviewed medical research[54] have unequivocally and repeatedly proven that medication assisted therapies like methadone are the most effective treatments for opioid dependence.[55]

Yet, extensive federal and state regulations and restrictions stand in the way of providing methadone, and to a lesser extent, buprenorphine treatment services to patients.[56] Access to methadone is extremely restricted in the United States and many people who need it cannot obtain it.[57] All told, only about 12 percent of individuals with opioid dependence receive methadone treatment.[58] Ultimately, methadone should be available by prescription and through doctors' visits, as it is in Canada and most of Western Europe.[59]

Access to treatment inside criminal justice settings

People who use opioids are at highest risk of overdose following a period of abstinence or reduced use that leads to lowered tolerance, such as spending time in a rehabilitation facility or serving a court-ordered period of incarceration.[60] For this reason, integration of medication assisted treatment and overdose prevention strategies into criminal justice settings is critical. Many populations, including incarcerated veterans, are acutely vulnerable during the period shortly after their release from jail or prison. People who inject heroin have seven times the risk of death from an overdose during the first two weeks after their release from incarceration.[61]

A growing number of jurisdictions have begun offering medication assisted treatment, overdose prevention and naloxone in criminal justice settings. In New Mexico, the Metropolitan Detention Center for Bernalillo County Methadone Maintenance program, which was launched in 2005, provides a daily dose of methadone to incarcerated people who were previously enrolled in a community-based methadone program. A study by the University of New Mexico indicates that incarcerated people receiving methadone treatment at the Metropolitan Detention Center typically stayed out of jail longer than incarcerated people who did not receive the treatment.[62] In Rhode Island, the state's Department of Corrections has partnered with a community-based overdose prevention program to train incarcerated individuals on how to prevent overdose and use naloxone prior to their release.[63]

People who use opioids illicitly are also vulnerable to arrest. For low-income residents of states that have not expanded Medicaid, the few, if not the only, way(s) for low-income and uninsured people to continue to obtain access to drug treatment or mental health services is to get arrested and hope for participation in a drug, mental health, or other specialty court or diversion program.

In these courts, judges and prosecutors – not healthcare providers – have final say over the defendant's participation in treatment, and usually require costly, abstinence-based episodes of treatment. Non-adherence to the program often results in incarceration. Individuals who are participating in a drug court have often been ordered by a drug court judge to leave methadone or buprenorphine treatment in

order to participate in the diversion program – making it very likely that those going through drug court will relapse and be sent to prison.[64] Moreover, some family court judges require clients to cease methadone treatment before they can receive custody of their children.[65] The Obama administration recently announced it would bar federal funding for drug courts that do not allow participation in medication assisted treatment programs.[66] The Committee should review legislative options for improving the delivery of medication assisted treatment and overdose prevention strategies in federal and state correctional facilities.

Policing

An increasing number of jurisdictions have recognized that the current approach of arresting people for illicit opioid possession and other low-level, nonviolent crimes has proven to be fiscally unsustainable and an ineffective strategy for improving the public safety and health of a community. The existing approach moves a relatively small fraction of offenders off the streets, for brief periods of time, and at a significantly higher cost than non-criminal justice system interventions. Criminalization of possession of small amounts of drugs and paraphernalia for personal use contributes to the marginalization of people who use illicit drugs. The resulting stigma attached to heroin or unsanctioned opioid analgesic use can exacerbate dependence and overdose risk. Further, the system diverts limited law enforcement resources from more serious crimes to policing low level drug offenses, with little to no improvement in neighborhood quality of life or a reduction in drug related deaths.

Law enforcement officers typically have more day-to-day interaction with marginalized populations than traditional service providers. They see firsthand the revolving door of jail to street for these populations. There is now a growing interest both inside and outside the law enforcement community in exploring new approaches to dealing with drug possession and other low-level crimes that that don't rely on arrest and incarceration.

In 2011, Seattle pioneered a new approach known as Law Enforcement Assisted Diversion, or LEAD, the first pre-booking diversion program in the country. LEAD was established through a unique collaboration between Seattle police, district attorneys, government agencies, mental health and drug treatment providers, housing providers and other service agencies, the business community, public defenders, elected officials and community leaders. LEAD seeks to reduce criminal behavior and improve public safety and order by connecting people who commit low level nonviolent crimes with community-based treatment and supportive services. Following Seattle's direction, Santa Fe, New Mexico implemented its own LEAD program in 2014.

Law Enforcement Assisted Diversion

Under LEAD, police officers exercise discretionary authority at the point of contact to divert individuals for low-level criminal offenses. Instead of arresting and booking people for certain nonviolent crimes, including low-level drug possession and sales, police may immediately connect them to a case manager who links people to housing, treatment and other services.[67] LEAD is designed to work with people

struggling with addiction and/or mental illness whose criminal behavior is motivated by addiction and subsistence needs.

Individuals diverted into LEAD receive intensive case-management and targeted services in a highly-coordinated environment. LEAD devotes a substantial portion of its resources to health and supportive services, and participants are given immediate access to services without displacing voluntary treatment candidates. An Individual Intervention Plan is provided for each participant, which serves as the action blueprint for the participant and his or her case manager. This plan may include assistance with housing, treatment, education, job training, job placement, licensing assistance, small business counseling, child care, or other services. Intensive case management provides increased support and assistance in all aspects of the participant's life.

LEAD is based on a harm reduction and housing first philosophy that requires a focus on individual and community wellness, rather than an exclusive focus on sobriety. LEAD participants, who are usually struggling with drug addiction and are often homeless, sometimes take months or even years to make major behavior changes. LEAD is designed to promote patience and relationship-building that can eventually yield results that shorter-term strategies cannot.

LEAD is a promising alternative to expensive court-based interventions that does not require the presence of judges, court staff, prosecutors, or public defenders. Rather, police officers determine whether or not individuals are appropriate to go into LEAD. Each local jurisdiction that implements LEAD defines its target population.

LEAD recognizes that drug use is a complex problem and people need to be reached where they currently are in their lives. In Seattle, LEAD precipitated a fundamental policy reorientation, from an "enforcement-first" approach, to a health-centered model – reinforced by specialized harm reduction training required of every police officer.

Law enforcement have been supportive of LEAD because it gives them additional tools to handle public safety issues. Diversion of people accused of low-level nonviolent crimes into LEAD allows law enforcement to focus on serious crime while playing a key role in linking people to services instead of funneling them into the justice system.

The Expansion of LEAD to Respond to Unique Local Concerns

New Mexico has the second highest drug-induced death rate in the nation, and the consequences of drug use continue to burden New Mexico communities. Drug induced deaths in Santa Fe County in 2014 was 30.9 per 100,000, up from 24.3 between 2007 and 2011. Santa Fe County had the fourth highest number of drug-induced deaths[68] across the state. In New Mexico, drug overdose deaths have now surpassed car accidents as the leading cause of death.[69]

Santa Fe experienced an increase in property crimes while at the same time experienced an increased use of opiates, both heroin and opiate-based pills. In 2011, the Santa Fe area (the city and the county, including parts of Española) ranked second in the country in residential burglaries per 100,000 residents.[70] Property crimes rose

slightly in 2012 compared to 2011. Residential burglaries increased to 802 from 782 the previous year.[71] Local authorities established that serious drug dependence was fueling the property crime problem.

The city of Santa Fe resolved to address these public safety and public health issues by forming a LEAD Task Force. The Task Force completed a cost-benefit analysis. The task force's analysis determined that the overall cost to the entire system to arrest 100 individuals by the City of Santa Fe Police Department for opiate possession or sales resulting in booking, detention, prosecution and/or adjudication costs was more than $4.2 million or an average of $42,000 per individual across the law enforcement, jail, judicial, 911 emergency and medical systems over just a three year (2010-2012) period alone.[72]

These same 100 individuals cost the City of Santa Fe one million dollars in jail/detention costs over three years for a total of 11,502 jail days. They were arrested 590 times by city police during that three year period and officers spent 9.3 hours per arrest. The majority of these individuals (91 out 100) were repeat offenders. This pattern of persistent recidivism resulted in individuals being re-arrested every six months on average. Fifty-one percent of those individuals had reported property crime histories. Based on these findings, the city acknowledged that it could no longer afford to rely on criminal sanctions to address problematic, drug-related behavior. To break this cycle of addiction and arrest, Santa Fe's City Council approved the implementation of a three-year pilot LEAD project.

LEAD is a Successful Program that Merits Replication

LEAD is credited with reducing drug arrests in Seattle by more than 30 percent from 2010 to 2011.[73] In addition, an independent, case-controlled outcome evaluation of Seattle's LEAD shows that it has resulted in significant reductions in recidivism.[74] Finally, a study released last month found statistically significant reductions in criminal justice and legal system costs for LEAD participants compared to the control group.[75]

LEAD is an evidence-based program that promotes best practices in responding to low level drug crimes. This Committee should advance federal legislation that would authorize funding to support the implementation of pilot LEAD initiatives by jurisdictions desiring a new approach to low-level nonviolent crime.

The Obama Administration's Response to Opioid Crisis

The Obama Administration has taken several important steps to mitigate risks associated with use, dependence and overdose. Earlier this year, the U.S. Department of Health and Human Services (HHS) announced a new initiative focused on reforming opioid analgesic prescribing practices, expanding the use of naloxone and expanding the use of medication assisted treatment. Notably, HHS concluded that expanding the use of naloxone and scaling up access to medication assisted treatment represented strategies grounded in the best research and clinical science available. Yet, funding to carry out this initiative is largely contingent on Congress approving a request for $133 million in President Obama's FY 2016 budget.[76] The Office of National Drug Control Policy (ONDCP) has also taken significant steps to recognize

naloxone's integral role in reversing opioid overdose deaths. ONDCP's most recent *National Drug Control Strategy* articulates policy goals of reducing overdose fatalities by 15 percent, increasing the utilization of naloxone by first responders and working with states to promote Good Samaritan Laws.[77]

Conclusion

The Drug Policy Alliance urges the Committee to confront the opioid crisis as a health issue, rather than a criminal justice issue and develop policies and programs accordingly. The federal government has spent billions of dollars on counterproductive supply-side strategies. The Committee should prioritize the elimination of federal roadblocks to accessible and affordable medication assisted treatment and facilitate the expansion of policy and programmatic solutions that address core issues that drive opioid and other substance use -- including Law Enforcement Assisted Diversion and Good Samaritan immunity laws.

The Committee should advance legislation that will reduce barriers to health services, drug treatment and emergency services -- including sterile syringes and naloxone.

Thank you for considering our views.

Sincerely,

Grant Smith
Deputy Director, National Affairs
Drug Policy Alliance

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[1] Carla K. Johnson, "Rapid rise seen in fatal medication errors." *Associated Press*, July 29, 2008.
[2] Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA et al. *Association between opioid prescribing patterns and opioid overdose-related deaths.* JAMA. 2011;305(13):1315-21.; Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. *Opioid dose and drug-related mortality in patients with nonmalignant pain.* Arch Intern Med 2011;171(7): 686–91.; Paulozzi LJ, Kilbourne EM, Shah NG, Nolte KB, Desai HA, Landen MG et al. *A history of being prescribed controlled substances and risk of drug overdose death.* Pain Med. 2012;13(1):87-95.
[3] Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services: Hearing before the U.S. Senate Subcommittee on Crime and Drugs Committee on the Judiciary and the Caucus on International Narcotics Control: Trends in Unintentional Drug Overdose Deaths. 110th Congress, (2008) (statement of Leonard J. Paulozzi, MD, MPH, medical epidemiologist in the Division of Unintentional Injury Prevention of the National Center for Injury Prevention and Control (NCIPC)).
[4] Centers for Disease Control and Prevention, National Center for Health Statistics. *Compressed Mortality File 1999-2013*, released October 2014, ICD-10 X40-X44, data are from the Compressed Mortality File 1999-2013 Series 20 No. 2S, 2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, accessed on May 29, 2015, http://wonder.cdc.gov/cmf-icd10.html.
[5] In 2003, 18,294 accidental drug overdoses were recorded by the CDC; in 2013, 35,663 accidental drug overdoses were recorded by the CDC.

[6] In 2000, 11,712 accidental drug overdoses were recorded by the CDC; in 2013, 35,663 accidental drug overdoses were recorded by the CDC

[7] White and American Indian men aged 45-54 residing in rural areas (especially in the Appalachian region of the Southeast) who use opioid analgesics on a daily basis, along with other prescription medications, are at greatest risk of experiencing a fatal overdose. Women, however, are increasingly at risk of a fatal opioid analgesic overdose. Between 1999 and 2010, opioid medication overdose fatalities increased by more than 400 percent among women and 265 percent among men. Military veterans are at also at elevated risk of experiencing a drug overdose. The risk of fatal overdose among military veterans is high given the widespread use of opioid analgesics for relief of pain from combat injuries.

[8] Since the mid-1990s, nearly all 50 states and the District of Columbia have passed laws creating PDMPs, which are government administered databases that collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. See: PDMP Training and Technical Assistance Center, "PDMP Frequently Asked Questions." http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq.

[9] At the federal level, the Obama Administration has prioritized efforts to restrict access to opioid analgesics. Many states continue to push forward with additional restrictions. The federal government has also provided funding in recent years for states to implement PDMPs. The Office of National Drug Control Policy (ONDCP) has promoted PDMPs and coordinated federal-state crackdowns on pain physicians, patients and illicit sellers. The DEA has aggressively investigated and prosecuted pain physicians for prescribing practices that this law enforcement agency viewed were outside the scope of legitimate medical practice. An FDA panel recently recommended the placement of opioid analgesic hydrocodone (Vicodin™) in the most restrictive federal controlled substance schedule. See: The White House, *National Drug Control Strategy*, (Washington DC: The White House, 2014), pages 74, 76-77, https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf ; Mark Potter, "Drug Enforcement Administration Raids 'Pill Mills' in Four Southern States," *NBC News*, May 20, 2015, http://www.nbcnews.com/news/us-news/drug-enforcement-administration-raids-pill-mills-four-southern-states-n361956; Drug Enforcement Administration. *DEA Announces Largest-Ever Prescription Drug Operation: Four State Takedown Targets Dirty Doctors, Pharmacies, Pill Mills*, (New Orleans: DEA, 2015), 1, http://www.dea.gov/divisions/no/2015/no052015.shtml ; Sabrina Tavernise, "F.D.A. Likely To Add Limits On Painkillers," *The New York Times*, January 26, 2013, http://www.nytimes.com/2013/01/26/health/fda-vote-on-restricting-hydrocodone-products-vicodin.html?_r=0 ; Fran Lowry, "FDA Panel Calls for Greater Restrictions on Hydrocodone," *Medscape*, Jan 28, 2013, http://www.medscape.com/viewarticle/778275; A growing number of states are requiring physicians and pharmacists to register and enter prescriptions into a state's PDMP. (See: Prescription Drug Monitoring Program Center of Excellence at Brandeis, "COE Briefing Mandating PDMP Participation by Medical Providers: Current Status and Experience in Selected States," last modified February 1st, 2014, http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf); Since 2003, Congress has authorized $80,350,000 in funding for the Harold Rogers Prescription Drug Monitoring Programs Grant, which is credited with aiding the creation of PDMPs in 33 states since 2003. The Obama Administration has also prioritized "law enforcement efforts to decrease pill mills, drug trafficking and doctor shopping" since 2011. See: Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, "Harold Rogers Prescription Drug Monitoring Program," Presentation to 19th National Conference on Pharmaceutical and Chemical Diversion (2010), See http://www.deadiversion.usdoj.gov/mtgs/drug_chemical/2010/rrose.pdf ; Erin Bagalman, Kristin Finklea, Lisa N. Sacco, "Prescription Drug Monitoring Programs," (Washington DC: Congressional Research Service, 2014) 15-16, https://www.fas.org/sgp/crs/misc/R42593.pdf ; Lisa N Sacco, Erin Bagalman and Kristin Finklea, *Prescription Drug Monitoring Programs*, (Washington: Congressional Research Service, 2014), 1-23, http://www.fas.org/sgp/crs/misc/R42593.pdf; The White House, National Drug Control Strategy, (Washington D.C.: White House, 2014), pages 74, 76-77, https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf

[10] A 2011 CDC study concluded as much, and a more recent literature review of 60 references concluded that evidence merely "suggested" that PDMPs have the intended impact. See: L Paulozzi, L Kilbourne, H Desai, "Prescription drug monitoring programs and death rates from drug overdose," *Pain Med* 12 (2011):747-754.; Prescription Drug Monitoring Program Center of Excellence at Brandeis, "COE Briefing
Mandating PDMP Participation by Medical Providers: Current Status and Experience in Selected States," last modified February 1st, 2014, http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf.

[11] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *2013 National Survey on Drug Use and Health: Summary of National Findings*, (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014), 31-32.

http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm.

[12] Holly Hedegaard, Li-Hui Chen, Margaret Warner, "Trends in Drug-Poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999–2012," (Hyattsville, MD: Centers for Disease Control and Prevention, 2014), 1-5; Michelle Peavy et al., ""Hooked on" Prescription-Type Opiates Prior to Using Heroin: Results from a Survey of Syringe Exchange Clients," *Journal of Psychoactive Drugs* 44, no. 3 (2012); R. A. Pollini et al., "Problematic Use of Prescription-Type Opioids Prior to Heroin Use among Young Heroin Injectors," *Substance Abuse Rehabilitation* 2: 1 (2011); K. Goodnough & K Zezima, "Drug is Harder to Abuse, but Users Persevere," *New York Times*, June 15, 2011, http://www.nytimes.com/2011/06/16/health/16oxy.html; George Jay Unick, Daniel Rosenblum, Sarah Mars, Daniel Ciccarone, "Intertwined Epidemics: National Demographic Trends in Hospitalizations for Heroin- and Opioid-related Overdoses, 1993-2009," *Plos One* (2013), doi: 10.1371/journal.pone.0054496; Pradip K. Muhuri, Joseph C. Gfroerer, and M. Christine Davies, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, *Substance Abuse and Mental Health Services Administration*, (Rockville, MD, Center for Behavioral Health Statistics and Quality, 2013), 1-17. http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf; Theodore J. Cicero, Matthew S. Ellis, and Hilary L. Surratt, "Effect of Abuse-Deterrent Formulation of Oxycontin," *New England Journal of Medicine* 367, 2 (2012): 187-189; U.S. Department of Justice, National Drug Intelligence Center, *National Drug Threat Assessment 2003*, (Washington DC: DOJ, 2003), 1-3, http://www.justice.gov/archive/ndic/pubs3/3300/pharm.htm; U.S. Department of Justice, National Drug Intelligence Center, *National Drug Threat Assessment 2011*, (Washington DC: DOJ, 2011): 37, http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf.

[13] Heroin is more potent, readily available, and a cheaper alternative to prescription opioids. Today, a dose of high-grade heroin is available for about the price of a six-pack of beer. See: Theodore J. Cicero, Matthew S. Ellis, Hilary L. Surratt, SP Kurtz, "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years," *JAMA Psychiatry* 71 (2014):821-826.; United Nations Office on Drugs and Crime, *World Drug Report 2014*, (New York: UN, 2014), 30, http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf (assuming purchase in the US of an IV dose of 10 mg – would be between $3-5 on average in US).

[14] Factors that contribute to a greater overdose risk include taking new batches of street heroin, buying from a new source selling a stronger drug, or from the presence of adulterants that increase the potency of heroin. The most notable of these additives is fentanyl, a potent synthetic opioid analgesic that is relatively easy to make and to smuggle. Fentanyl, whether in prescription or illegal analog form, is many times more potent than morphine. When added to heroin, fentanyl can cause immediate overdose in unsuspecting users. In 2005-2006, nearly 1,000 people died from a batch of fentanyl-laced heroin in six Midwestern and northeast states. More recently, fentanyl-laced heroin was traced to 17 deaths in Pittsburgh and over 50 in Philadelphia, Pennsylvania in early 2014. Another factor influencing heroin overdose rates is the simultaneous use of multiple drugs, such as alcohol, cocaine and other depressants. See: A Weil, *From Chocolate to Morphine*, (New York: Houghton Mifflin Company, 1998), 161-163.; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Nonpharmaceutical Fentanyl-Related Deaths – Multiple States, April 2005--March 2007" *Morbidity and Mortality Weekly Report 57 29* (July 2008): 793-796, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm.; Substance Abuse and Mental Health Services Administration (SAMHSA), "Advisory to Treatment Community on The Danger of Heroin Contaminated with Fentanyl and What Can be Done to Save Lives," February 07, 2014, http://www.samhsa.gov/newsroom/press-announcements/201402071000; Don Sapatkin, "Deadly drug mix: Fentanyl Makes a Comeback," *Philly.com*, August 24, 2014, http://articles.philly.com/2014-08-24/news/53143422_1_illicit-fentanyl-overdoses-heroin.; Coffin, P.O., S. Galea, J. Ahern, A.C. Leon, D. Vlahov, and K. Tardiff, "Opiates, Cocaine and Alcohol Combinations in Accidental Drug Overdose Deaths in New York City, 1990-98." *Addiction* 98 (2003): 739-47.

[15] Holly Hedegaard, Li-Hui Chen, Margaret Warner, "Drug-poisoning Deaths Involving Heroin: States, 2000-2013," *NCHS Data Brief* 190 (2015), 1-8, http://www.cdc.gov/nchs/data/databriefs/db190.pdf.

[16] Holly Hedegaard, Li-Hui Chen, Margaret Warner, "Drug-poisoning deaths involving heroin: States, 2000-2013," *NCHS Data Brief* 190 (2015), 1-8, http://www.cdc.gov/nchs/data/databriefs/db190.pdf; RA Rudd, LJ Paulozzi, MJ Bauer, RW Burleson, RE Carlson, D Dao, et al., "Increases in Heroin Overdose Deaths - 28 States, 2010 to 2012," *Morbidity and Mortality Weekly Report* 2014; 63(39):849-54; Centers for Disease Control and Prevention, Data for Epidemiologic Research (CDC WONDER), http://wonder.cdc.gov/.

[17] Evidence suggests that the switch from using opioid analgesics to using heroin is particularly prevalent for individuals who are using opioid analgesics without a prescription. However, available evidence does not support the notion that individuals who use opioid analgesics will progress to using

heroin for the purpose of experiencing a more potent drug alone. See: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013," *Morbidity and Mortality Weekly Report*, 64(26) (2015): 719-725, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w; NIDA Report Series, "Heroin," NIH publication number 15-0165, 3 (November 2014, rev.); TJ Cicero, MS Ellis, HL Surratt, "Effect of Abuse-deterrent Formulation of OxyContin," *New England Journal Medicine* 367.2 (2012):187–189; National Institute on Drug Abuse, *Epidemiologic Trends in Drug Abuse, in Proceedings of the Community Epidemiology Work Group*, (Bethesda, MD: NIDA, 2012); Amy Pavuk, "Rx for Danger: Oxycodone Crackdown Drives Addicts to Other Drugs," *Orlando Sentinel*, July 28, 2012, http://articles.orlandosentinel.com/2012-07-28/health/oso-oxycodonedrug-shift-dilaudid-20120728_1_oxycodone-prescription-drugs-dilaudid-pills ; Theodore J. Cicero, Matthew S. Ellis, Hilary L. Surratt, Steven P. Kurtz, "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 years," *JAMA Psychiatry* 71 (2014): 821-6.)

[18] Lisa N Sacco, Erin Bagalman and Kristin Finklea, *Prescription Drug Monitoring Programs*, (Washington: Congressional Research Service, 2014), 1-23, http://www.fas.org/sgp/crs/misc/R42593.pdf.

[19] Katherine Addleman, "Undertreated pain festers in our anti-opiate culture," *National Review of Medicine* 1 (30 August 2004); Maia Szalavitz, "Report: Chronic, Undertreated Pain Affects 116 Million Americans," *Time*, June 29, 2011, http://healthland.time.com/2011/06/29/report-chronic-undertreated-pain-affects-116-million-americans/; Human Rights Watch, *Global State of Pain Treatment: Access to Medicines and Palliative Care* (New York, NY: HRW, 2011) 5-10, 16-17, http://www.hrw.org/sites/default/files/reports/hhr0511W.pdf; NB King, V Fraser, "Untreated Pain, Narcotics Regulation, and Global Health Ideologies," *PLoS Medicine* 10.4 (2013), http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001411; Institute of Medicine, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, (Washington, DC: National Academies Press, 2011), http://img.medscape.com/pi/features/pain/IOM_RelievingPainAmerica_June2011pdf.pdf

[20] US Census Bureau, *The Next Four Decades: The Older Population in the United States: 2010 to 2050, Population Estimates and Predictions*, (Washington DC: US Census Bureau, 2011), 1-16.

[21] Institute of Medicine of the National Academies, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (Washington D.C.: The National Academies Press, 2011), 8, 62-64, 81.

[22] Naloxone is an opioid antagonist that blocks the brain cell receptors activated by heroin and other opioids, temporarily restoring normal breathing within two to three minutes of administration. First approved by the FDA in 1971, naloxone is effective at reversing opioid overdoses precipitated by the use of heroin, oxycodone (OxyContin™), hydrocodone (Vicodin™), percocet, methadone, fentanyl and other opioids. Naloxone's only effects are to reverse respiratory failure resulting from an opioid overdose and to cause uncomfortable withdrawal symptoms in the dependent user. It has no pharmacological effect if administered to a person who has not taken opioids and has no potential for abuse. It is impossible to overdose on naloxone. See: United Nations Office on Drugs and Crime, *Opioid Overdose: Preventing And Reducing Opioid Overdose Mortality*, (New York: United Nations, 2013), 7. https://www.unodc.org/docs/treatment/overdose.pdf.

[23] If the victim has not been revived after two minutes, another dose of naloxone is administered and so on until the naloxone has the desired effect. Naloxone's effects last for 30 to 75 minutes, allowing time for the arrival of emergency medical assistance. Naloxone is most commonly administered via intramuscular injection, but it can also be administered intranasally using an atomizer device that delivers a mist to the nasal mucus membrane. The intranasal device delivers the intramuscular formation of naloxone. The intramuscular formulation has not yet been formally approved by the FDA for intranasal delivery, but it is in use by EMS responders and law enforcement in a growing number of states and by government health providers and community-based overdose prevention initiatives across the country, and the FDA is expected to soon approve an intranasal formulation of naloxone. Last year, the FDA approved a third method of naloxone delivery by way of an auto-injector delivery system (Evzio™). While the recent arrival of Evzio™ on the market provides health care providers and patients at-risk of an overdose with an important new treatment option, and is covered by some insurance providers, the newly patented auto-injector can be too expensive for the uninsured to access. See: United Nations Office on Drugs and Crime, *Opioid Overdose: Preventing And Reducing Opioid Overdose Mortality*, (New York: United Nations, 2013), 8, https://www.unodc.org/docs/treatment/overdose.pdf ; Robert "Skip" Nelson, MD PhD, Senior Pediatric Ethicist & Lead Medical Officer, Office of Pediatric Therapeutics, US Food and Drug Enforcement Administration, "Presentation: Ethical and Regulatory Considerations in Drug Development for IN Naloxone," slide 3, http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300877.pdf; Krystle Vermes, "Pharmacist

Develops Naloxone Nasal Spray to Reverse Drug Overdoses," *Pharmacy Times*, August 27, 2014, http://www.pharmacytimes.com/product-news/Pharmacist-Develops-Naloxone-Nasal-Spray-to-Reverse-Drug-Overdoses; U.S. Food and Drug Administration, "FDA Approves New Hand-held Auto-injector to Reverse Opioid Overdose," *FDA*, April 3, 2014, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm391465.htm; Elisabeth Rosenthal, "For Drugs That Save Lives, a Steep Cost," *New York Times*, April 26, 2014, http://www.nytimes.com/2014/04/27/sunday-review/it-will-save-lives-but-whats-the-cost.html?_r=0; Arielle Pardes, "How the Pharmaceutical Industry Is Making Money on Your Overdose," *VICE Magazine*, July 14, 2014, http://www.vice.com/read/overdoses-are-insanely-profitable-for-pharmaceutical-companies-714

[24] Phillip O. Coffin and Sean D. Sullivan, "Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal," *Annals of Internal Medicine* 158, (2013), 1057.

[25] Depending on state law, prescriptions for naloxone must either be written to individuals who have requested to carry the medication or may be made by overdose prevention programs operating under standing orders from a physician. Access to naloxone and other emergency treatment is also often limited at the state-level by laws and regulations that were implemented before opioid overdose fatalities began climbing in the 2000s. In an attempt to improve utilization of naloxone by health practitioners and laypeople, a number of states have recently amended their laws to increase access to emergency care and treatment for opioid overdose. Naloxone is governed by state and federal prescription drug laws. State practice laws generally discourage or prohibit the prescription of drugs to a person other than the person to whom they will be administered (a process referred to as third-party prescription) or to a person the physician has not personally examined (a process referred to as prescription via standing order). After years of federal prosecutions against physicians accused of professional negligence or corruption for prescribing opioids, health practitioners supportive of naloxone availability are understandably concerned about potential liabilities stemming from prescribing the medication for third-party use. Likewise, even where naloxone is available, bystanders to a drug overdose may be afraid to administer it because of liability concerns. Other states provide a standing order for community-based organizations who distribute naloxone to those who meet certain criteria. See: Network for Public Health Law, Legal Intervention to Reduce Overdose Mortality: Emergency Medical Services Naloxone Access, available at https://www.networkforphl.org/_asset/8b7kmi/EMS-naloxone-overview.pdf.; Sporer, K. A., A. H. Kral. "Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention." *Annals of Emergency Medicine* 49 (2007): 172-77.; Burris, S. Norland, J. Edlin, B.R. "Legal Aspects of Providing Naloxone to Heroin Users in the United States." *International Journal of Drug Policy* 12 (2001): 237-248.; Leo Beletsky, et al., "Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities," *Journal of Urban Health* 84 (2007). 126.; Scott Burris, et al, "Stopping An Invisible Epidemic: Legal Issues In The Provision Of Naloxone To Prevent Opioid Overdose," *Drexel Law Review* 273 (2009), 273-340.

[26] Network for Public Health Law, Legal Intervention to Reduce Overdose Mortality: Emergency Medical Services Naloxone Access, available at https://www.networkforphl.org/_asset/8b7kmi/EMS-naloxone-overview.pdf.

[27] See Opioid Overdose Reduction Act of 2015, H.R. 1821

[28] Severe penalties for possession and use of illicit drugs, including state laws that impose criminal charges on individuals who provide drugs to someone who subsequently dies of an overdose, only intensify the fear that prevents many witnesses from seeking emergency medical help. See: C. J. Banta-Green et al., "Police Officers' and Paramedics' Experiences with Overdose and Their Knowledge and Opinions of Washington State's Drug Overdose-Naloxone-Good Samaritan Law," *J Urban Health* 90.6 (2013), 1103-1110.; Karin Tobin, et al., "Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social and Setting Correlates," *Addiction* 100 (2005), 397-404; Robin A. Pollini, et al., "Response to Overdose Among Injection Drug Users," *American Journal of Preventive Medicine* 31 (2006), 261-263.

[29] Good Samaritan Laws have been passed in: NM, AK, AR, CA, CO, CT, DE, FL, GA, IL, KY, LA, MA, MD, MN, MS, NC, NJ, NV, NY, PA, RI, VT, WA, WI, and WV) and the District of Columbia.

[30] Normand J, Vlahov D, Moses LE, et al., "Preventing HIV Transmission: The Role of Sterile Needles and Bleach," (Washington, DC: National Academies Press, 1995), http://www.nap.edu/books/0309052963/html.

[31] World Health Organization, "People who inject drugs," last updated February 2015., http://www.who.int/hiv/topics/idu/en/

[32] Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER, "Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-exchange Participation in Seattle Drug Injectors," *Journal of Substance Abuse Treatment* 19 (2000): 247–252; Don C. Des Jarlais, Vivian Guardino, Kamyar Arasteh, Courtney McKnight, Judith Milliken and David Purchase, "Current State of Syringe Exchange in the Known Universe." NASEC, last modified

November 17, 2010, http://www.nasen.org. Also, syringe exchange programs also provide safe disposal of infected syringes, which reduces the risk of accidental needlestick injuries to first responders and public encounters with discarded syringes. Moreover, syringe exchange programs provide crucial support for participants at every point along the continuums of care for HIV and hepatitis C.

[33] US Department of Health and Human Services, *Evidence-based findings on the efficacy of syringe exchange programs: an analysis of the scientific research completed since April 1998*, (Washington DC:US Department of Health and Human Services, 2000), 1-19.; Institute of Medicine (IOM), *Preventing HIV Infection among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence* (Washington DC: National Academies Press, 2006), 1-2, http://www.iom.edu/~/media/Files/Report%20Files/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence/11731_brief.pdf; World Health Organization (WHO), *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users* (Geneva, Switzerland: WHO, 2004), http://www.who.int/hiv/pub/prev_care/effectivenessSterileneedle.pdf; Center for Disease Control, "Syringe Exchange Programs – United States, 2005," Morbidity and Mortality Weekly 56,44 (2005): 1164-1167, http://www.cdc.gov/IDU/facts/AED_IDU_SYR.pdf; National Institute on Drug Abuse, *Principles of HIV Prevention in Drug-using Populations: A Research Based Guide* (Washington DC: NIH, 2002), 1-32; Melissa Marx et al., "Trends in Crime and the Introduction of a Needle Exchange Program," *American Journal of Public Health*, 90,12 (2000):1933–6. Also, for every dollar invested in syringe access, approximately $3-8 in HIV treatment are saved. This does not take into account further savings from averted hepatitis C infection, avoiding increased healthcare expense due to living with the virus. Examples of the effectiveness of syringe exchange programs in scientific literature are numerous. The CDC estimates that HIV diagnoses among people who inject drugs has declined by 70 percent in the 10-year period, from 2002 to 2011. Many attribute a 70 percent decline in HIV diagnoses among people who inject drugs between 2002 and 2011 to the provision of comprehensive, science-based HIV prevention programs for this population, including syringe services programs. Similarly, the New York State Department of Health credits syringe exchange programs with a major reduction in HIV/AIDS across that state from 1992, when 52 percent of AIDS cases were attributed to injection drug use, to 2004, when only 5.4 percent of HIV cases were so attributed. The District of Columbia Department of Health expanded syringe exchange program access in 2007 and subsequently reported an 81 percent decrease in new HIV infections among people who inject drugs in D.C. from 2008-2012. See: A Wodak, A Cooney, "Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence," *Substance Use Misuse* 41 (2006):777–813.; A Johnson, H Hall, X Hu, A Lansky, DR Holtgrave, J Mermin, "Trends in Diagnoses of HIV Infection in the United States, 2002–2011" *JAMA* 312.4 (2014) 432–434. doi:10.1001/jama.2014.853.; New York State Department of Health, "Harm Reduction Initiative," accessed on May 28, 2015, http://www.health.ny.gov/diseases/aids/general/about/prev/up.htm#harmred ; District of Columbia Department of Health, *Annual Epidemiology & Surveillance Report*, (Washington DC: District of Columbia Department of Health, 2012), 17, http://doh.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Newly%20Diagnosed%20HIV%20Cases.pdf.

[34] amFAR, "Preventing HIV and Hepatitis C Among People Who Inject Drugs: Public Funding for Syringe Services Programs Makes the Difference," *amFAR Issue Brief* (2015), 1-5, http://www.amfar.org/uploadedFiles/_amfarorg/On_the_Hill/BIMC_SSP_IB-WEB-VERSION_041315.pdf p. 4; Also, the last two directors of the Office of National Drug Control Policy (ONDCP) have cited syringe services as essential to reducing the transmission of blood-borne diseases without increasing drug use when implemented in the context of a comprehensive program that offers referrals to other treatment and prevention services. See: White House Office of National Drug Control Policy, Senate Judiciary Committee confirmation hearing, 111th Congress, (2009), (statement of Gil Kerlikowske, Director of ONDCP); Bruce Schreiner, "McConnell, Drug Czar Talk Heroin in N. KY," *Associated Press*, April 9, 2015, http://www.courier-journal.com/story/news/local/2015/04/09/mcconnell-botticelli/25544135/

[35] amFAR, "Preventing HIV and Hepatitis C Among People Who Inject Drugs: Public Funding for Syringe Services, Programs Makes the Difference," *amFAR Issue Brief* (2015), 1-5 http://www.amfar.org/uploadedFiles/_amfarorg/On_the_Hill/BIMC_SSP_IB-WEB-VERSION_041315.pdf

[36] amFAR, "Syringe Services Program Coverage in the United States –June 2014," last modified in June, 2014, http://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2013/2013%20SSP%20Map%20Final.pdf

[37] As of April 17th, there were 120 confirmed and 10 preliminary positive cases of HIV from the sharing of drug injection equipment in Scott County, Indiana along the Kentucky border.[37] Public health

officials from the state of Indiana and CDC determined that the localized epidemic of new HIV cases was due to the sharing of syringes used to inject oxymorphone, an opioid analgesic.[37] In response, Republican Indiana Governor Mike Pence declared a public health emergency in the affected county and issued an executive order allowing for the operation of a syringe exchange program.[37] The Indiana legislature subsequently passed legislation authorizing local officials to request approval from the Indiana State Department of Health for a limited syringe exchange program in the event of a public health emergency.[37] See: Debra Goldschmidt, "Indiana governor declares public health emergency due to HIV epidemic," *CNN*, March 27, 2015, http://www.cnn.com/2015/03/27/health/indiana-hiv-outbreak/

[38] In response to a surge in hepatitis C cases in Kentucky, the state legislature passed a comprehensive bill earlier this year to address rising hepatitis C infections that included the legalization of syringe exchange programs in that state. Nationally, there is emerging evidence of a new surge in hepatitis C cases, with CDC reporting a 75 percent increase in new cases from 2010-2012. See: CDC, Division of Viral Hepatitis, "Reported Cases of Acute, Hepatitis C, by State—2008–2012," last modified August 28, 2014, http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Table4.1.htm

[39] Susan F. Hurley, Damien J. Jolley, and John M. Kaldor,"Effectiveness of Needle-Exchange Programmes for Prevention of HIV Infection," *The Lancet* 349, 9068 (1997): 1797-1800, http://www.druglibrary.org/schaffer/misc/effectiveness_of_neps_for_preven.htm (finding that that in 29 cities worldwide where needle exchange programs are in place, HIV infection dropped by an average of 5.8 percent a year among drug users. In 52 cities that did not have needle exchanges, drug-related infection rose an average of 5.9 percent each year).

[40] C.L. Arfken, et al., "Expanding Treatment Capacity for Opioid Dependence with Buprenorphine: National Surveys of Physicians," *Journal of Substance Abuse Treatment* 96, 39 (2010).

[41] William C. Becker, David A. Fiellinb, Joseph O. Merrilld, Beryl Schulmand, Ruth Finkelsteine, Yngvild Olsenf, Susan H. Busch, "Opioid use disorder in the United States/ Insurance Status and Treatment Access," *Drug and Alcohol Dependence*, Volume 94, Issues 1–3 (2008), 207-213, http://www.usatoday.com-story/news/2015/05/24/addiction-treatment-shortage/27181773/ ; The American Society of Addiction Medications, "Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment," (Chevy Chase, MD, ASAM: 2013), 10, 37, http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; James A. Peterson, Robert P. Schwartz, Shannon Gwin Mitchell, Heather Schacht Reisinger, Sharon M. Kelly, Kevin E. O'Grady, Barry S. Brown, Michael H. Agar, "Why don't out-of-treatment individuals enter methadone treatment programs?" *International Drug Policy 21* (2010):36-41.

[42] National Institute on Drug Abuse, "Medication-Assisted Treatment for Opioid Addiction," *NIDA Topics in Brief* (April 2012), https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

[43] The American Society of Addiction Medications, "Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment, Part II: Economic Evaluation of Pharmacotherapies for the Treatment of Opioid Disorders.." (Chevy Chase, MD, ASAM: 2013), 8, 65- 91, http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; M. Connock, et al., "Methadone and Buprenorphine for the Management of Opioid Dependence: A Systematic Review and Economic Evaluation," *Health Technology Assessment* 11, 9 (2007): 1-192.

[44] C. Banta-Green, et al., "Retention in Methadone Maintenance Drug Treatment for Prescription-Type Opioid Primary Users Compared to Heroin Users," *Addiction* 104 (2009): 775-783.

[45] Methadone, a Schedule II controlled substance used as maintenance treatment for documented opioid dependence for over 40 years, may only be dispensed by clinics, certified by SAMHSA, and subject to both Federal and state regulation. Buprenorphine, a Schedule III controlled substance – which may be offered, under certain circumstances, by methadone treatment clinics – is a more recently introduced synthetic opioid treatment medication approved as an outpatient physician-prescribed treatment for opioid dependence. Naltrexone is a physician-prescribed clinician-administered injectable medication for the prevention of relapse of opioid dependence after detoxification, commonly known by the brand name Vivitrol™. See: American Society of Addiction Medicine, *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment* (2013), http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioidaddiction-treatment_final

[46] The National Institutes of Health has explicitly recognized methadone is the most successful treatment to date for opioid dependence, and recommended a reduction in the unnecessary regulation of methadone maintenance therapy and other medication assisted treatment programs. National Institutes of Health, "Effective Medical Treatment of Opiate Addiction," *NIH Consensus Statement* 15, 6 (1997), 4, http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf; and National Institute on Drug Abuse (NIDA) "Research Report: Heroin Abuse and Addiction," (Revised 2005), http://www.drugabuse.gov/ResearchReports/heroin/heroin.html; and National Institute on Drug Abuse,

"Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide," (National Institutes of Health, 2006), 5, 22, https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf; and D.A. Fiellin, et al., "Methadone Maintenance in Primary Care: A Randomized Controlled Trial," *JAMA* 286 (2001):1764-1765; and J.C. Ball and A. Ross, *The Effectiveness of Methadone Maintenance Treatment* (New York: Springer-Verlag, 1991); and Y.I. Hser, et al., "A 33-Year Follow-Up of Narcotics Addicts," *Archives of General Psychiatry* 58 (2001): 503-508; and J. Ward, W. Hal, and R.P. Mattick, "Role of Maintenance Treatment in Opioid Dependence," *The Lancet* 353 (1999): 221-226; and D.M. Novick and H. Joseph, "Medical Maintenance: The Treatment of Chronic Opiate Dependence in General Medical Practice," *Journal of Substance Abuse Treatment* 8 (1991): 233-239; and Centers for Disease Control and Prevention, "Methadone Maintenance Treatment," February 2002, accessed June 4, 2015, http://www.cdc.gov/idu/facts/Methadone.htm; and M. Connock, et al., "Methadone and Buprenorphine for the Management of Opioid Dependence: A Systematic Review and Economic Evaluation," *Health Technology Assessment* 11, 9 (2007); Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (Tip) Series 43* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005); World Health Organization, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention* (United Nations Office on Drugs and Crime, 2004), http://www.unodc.org/docs/treatment/Brochure_E.pdf; and R.P. Mattick, et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database System Review*, 3 (2009).

[47] N.D. Volkow, et al., "Medication-Assisted Therapies —Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370, 22 (2014): 63; and R.P. Mattick, et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy For Opioid Dependence," *Cochrane Database System Review* 3 (2009).

[48] Centers for Disease Control and Prevention, "Methadone Maintenance Treatment," February 2002, http://www.cdc.gov/idu/facts/MethadoneFin.pdf.

[49] R.A. Rettig and A. Yarmolinksky, eds., *Federal Regulation of Methadone Treatment* (Washington, D.C.: National Academy Press, 1995), http://www.nap.edu/catalog.php?record_id=4899.

[50] National Institutes of Health, "Effective Medical Treatment of Opiate Addiction," *NIH Consensus Statement* 15, 6 (1997), 4, http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf.

[51] Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005), http://buprenorphine.samhsa.gov/tip43_curriculum.pdf.

[52] National Institute on Drug Abuse, "Research Report: Heroin Abuse and Addiction," Revised 2005, accessed June 4, 2015, http://www.drugabuse.gov/ResearchReports/heroin/heroin.html; NIDA International Program. Methadone Research Web Guide (Bethesda, National Institute on Drug Abuse: 2007); and National Institute on Drug Abuse, "Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide," (National Institutes of Health, 2006), 5, 22, https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf.

[53] World Health Organization, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention* (United Nations Office on Drugs and Crime, 2004), http://www.unodc.org/docs/treatment/Brochure_E.pdf.

[54] D.A. Fiellin, et al., "Methadone Maintenance in Primary Care: A Randomized Controlled Trial," *JAMA* 286 (2001):1764-1765; and J.C. Ball and A. Ross, *The Effectiveness of Methadone Maintenance Treatment* (New York: Springer-Verlag, 1991); and Y.I. Hser, et al., "A 33-year follow-up of narcotics addicts," *Archives of General Psychiatry* 58 (2001): 503-508; and J. Ward, W. Hal, and R.P. Mattick, "Role of Maintenance Treatment in Opioid Dependence," *The Lancet* 353 (1999): 221-226; and D.M. Novick and H. Joseph, "Medical Maintenance: The Treatment of Chronic Opiate Dependence in General Medical Practice," *Journal of Substance Abuse Treatment* 8 (1991): 233-239.

[55] Centers for Disease Control and Prevention, "Methadone Maintenance Treatment," 2002, accessed June 4, 2015, http://www.cdc.gov/idu/facts/Methadone.htm.; National Institutes of Health, *Effective Medical Treatment of Opiate Addiction*, NIH Consensus Statement 15 (1997); Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, Treatment Improvement Protocol (TIP) Series 43, DHHS (SMA) 05-4048, (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005); World Health Organization (WHO), Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper, (Geneva, Switzerland, World Health Organization, United Nations Office on Drugs and Crime, UNAIDS, 2004), http://www.unodc.org/docs/treatment/Brochure_E.pdf; DA Fiellin, M O'Connor, M Chawarski, et al., "Methadone Maintenance in Primary Care: A Randomized Controlled Trial," *Journal of the American Medical Association* 286 (2001):1764-1765; JC Ball and A. Ross, "The Effectiveness of Methadone Maintenance Treatment," New York: Springer-Verlag (1991); Hser Y-I, V

Hoffman, C.E. Grella, M.D. Anglin, "A 33-year Follow-up of Narcotics addicts," *Archives of General Psychiatry* 58 (2001): 503-508; Jeff Ward, Wayne Hall, Richard P Mattick, "Role of Maintenance Treatment in Opioid Dependence," *Lancet* 353 (1999): 221-226; DM Novick, and H. Joseph. "Medical Maintenance: The Treatment of Chronic Opiate Dependence in General Medical Practice," *Journal of Substance Abuse Treatment* 8 (1991): 233-239.; For more information, see Drug Policy Alliance, *About Methadone and Buprenorphine: Revised Second Edition* (New York: Drug Policy Alliance, 2006), http://www.drugpolicy.org/docUploads/aboutmethadone.pdf.

[56] Although federal law prohibits methadone from being prescribed in an office-based setting, federal law allows physicians to become eligible to prescribe buprenorphine (Suboxone ™) for the treatment of opioid dependence. Physicians that meet certain qualifications can become eligible to apply for a special waiver which allows them to treat opioid dependence with buprenorphine in an office-based setting. However federal law arbitrarily caps the number of opioid patients a physician can treat with buprenorphine at any one time to 30 through the first year following certification, expandable to 100 patients thereafter. Evidence also suggests that particular patients, namely low income, non-white patients, are less likely to access buprenorphine than more affluent white patients. See: Drug Addiction Treatment Act of 2000, Public Law 106-310.; H.B. Hansen, et al., "Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic, and Income Characteristics of Residential Social Areas in New York City," *Journal of Behavioral Health Services & Research* 40, 3 (2013): 367-77; and H.K. Knudsen, et al., "Early Adoption of Buprenorphine in Substance Abuse Treatment Centers: Data from the Private and Public Sectors," *Journal of Substance Abuse Treatment* 30, 4 (2006): 363-73; and A. Stanton, et al., "Expanding Treatment of Opioid Dependence: Initial Physician and Patient Experiences with the Adoption of Buprenorphine," American Society of Addiction Medicine presentation (March 2006), http://www.buprenorphine.samhsa.gov/ASAM_06_Final_Results.pdf; and J.D. Baxter, et al., "Factors Associated with Medicaid Patients' Access to Buprenorphine Treatment," *Journal of Substance Abuse Treatment* 41, 1 (2011):88-96.

[57] R.A. Rettig and A. Yarmolinsky, eds., *Federal Regulation of Methadone Treatment* (Institute of Medicine National Academy Press, 1995), 31; and H.D. Kleber, "Methadone Maintenance 4 Decades Later: Thousands of Lives Saved But Still Controversial," *JAMA* 300, 300 (2008): 2303-2305. Only 9 percent of substance abuse treatment facilities in the United States offer specialized treatment of opioid dependence with methadone or buprenorphine. Currently, with a few exceptions, methadone for the treatment of opioid dependence is only available through a highly regulated and widely stigmatized system of Opioid Treatment Programs (OTPs). Several states have also imposed moratoriums on establishing new OTPs that facilitate methadone treatment despite large, unmet treatment needs for a growing opioid-dependent population. Patients enrolled in methadone treatment in many communities are often limited to visiting a single OTP and other inconveniences that make adherence to treatment more difficult. See: Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS): 2011 Data, "Programs or Groups for Specific Client Types – Table 4.11b," (2013), http://www.samhsa.gov/data/DASIS/2k11nssats/NSSAT S2011Chp4.htm ; N.D. Volkow, et al., "Medication-Assisted Therapies: Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370, 22 (2014): 64-66; and U.S. Department of Health and Human Services. "HHS Takes Strong Steps to Address Opioid-Drug Related Overdose," March 26, 2015, http://www.hhs.gov/news/press/2015pres/03/20150326a.html; Cristina Redko, et al., "Waiting Time As A Barrier To Treatment Entry: Perceptions Of Substance Users," *Journal of Drug Issues* 37, 3 (2007): 831-852; and Cassie Castillo, "Opioid Maintenance Therapy: Questions and Controversies," *Huffington Post*, July 20, 2014, accessed May 28, 2015, http://www.huffingtonpost.com/tessie-castillo/opioid-maintenance-therap_b_5604200.html.

[58] D.W. Raisch, et al., "Opioid Dependence Treatment, Including Buprenorphine/Naloxone. Annals of Pharmacotherapy 36, 2 (February 2002):312-321.

[59] Benedikt Fischer, "Prescriptions, Power and Politics: The Turbulent History of Methadone Maintenance in Canada," *Journal of Health Policy* 21, 2 (2000): 187-210; and Ernst Buning, "Methadone in Europe," *International Journal of Drug Policy* 5, 4 (1994): 221-225. There has been a longstanding interest in mainstreaming addiction treatment by integrating it into primary and other health care settings. Initial trials have suggested that methadone can be effectively delivered in office-based settings, and that, with training, physicians would be willing to prescribe methadone to their patients to treat their opioid dependence. Office-based methadone may help reduce the stigma associated with methadone delivered in OTPs. See: M.J. Krantz and P.S. Mehler, "Treating Opioid Dependence: Growing Implications for Primary Care. Archives of Internal Medicine 164, 3 (2004): 277-288.; L. King, et al., "A Multicenter Randomized Evaluation of Methadone Medical Maintenance," *Drug and Alcohol Dependence* 65, 2 (2002):137-48; and D.A. Fiellin, et al., "Methadone Maintenance in Primary Care: A Randomized Controlled Trial," *JAMA* 286, 14 (2001):1724-31; and L.L. Krambeer, et al. "Methadone Therapy for Opioid Dependence," *American Family Physician* 63, 2 (2001):2404-10; M.

Wennrich and M. Stuart, "Provision of Methadone Treatment in Primary Care Medical Practices: Review of the Scottish Experience and Implications for US Policy," *JAMA* 283, 10 (2000):1343-1348.; J. McNeely, et al., "Office-Based Methadone Prescribing: Acceptance by Inner-City Practitioners in New York," *Journal of Urban Health* 77, 1 (2000): 96-102.; E.A. Salsitz, et al., "Methadone Medical Maintenance (MMM): Treating Chronic Opioid Dependence in Private Medical Practice-A Summary Report (1983-1998)," *Mt. Sinai Journal of Medicine* 67, 5-6 (2000):388-97.; L.L. Krambeer et al., "Methadone Therapy for Opioid Dependence," *American Family Physician* 63, 12 (2001):2404-2410.

[60] Azar Kariminia et al., "Suicide Risk Among Recently Released Prisoners in New South Wales, Australia," *Medical Journal of Australia* 187:7 (2007) 387-390; John Strang et al., "Loss of Tolerance and Overdose Mortality After Inpatient Opiate Detoxification: Follow up Study," *British Medical Journal* 326 (2003): 959-96; Michael Farrell and John Marsden, "Acute Risk of Drug-related Death Among Newly Released Prisoners in England and Wales," *Addiction* 103, 251–255 (2007); I. A. Binswanger et al.,"Release From Prison—A High Risk of Death For Former Inmates." *New England Journal of Medicine* 356 (2007): 157–65; Seaman et al. "Mortality from Overdose Among Injecting Drug Users Recently Released From Prison: Database Linkage Study," *British Medical Journal* 316 (1998): 426–8.; K.A. Sporer. A. H. Kral, "Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention," *Annals of Emergency Medicine* 49 (2007): 172-77.; K.A. Sporer, "Strategies for Preventing Heroin Overdose," *British Medical Journal* 326 (2003): 442-444; Sandro Galea, Jennifer Ahern, David Vlahov, Phillip O. Coffin, Crystal Fuller, Andrew C. Leon, Kenneth Tardiff, "Income Distribution and Risk of Fatal Drug Overdose in New York City Neighborhoods," *Drug and Alcohol Dependence* 70 (2003): 139-148; Phillip O. Coffin, Melissa Tracy, Angela Bucciarelli, Danielle Ompad, David Vlahov, Sandro Galea, "Identifying Injection Drug Users at Risk of Nonfatal Overdose," *Academic Emergency Medicine* 14 (2007): 616-623; Binswanger, I.A. et al. "Release from Prison – a High Risk of Death for Former Inmates," *New England Journal of Medicine* 157 (2007): 356; K.H. Seal, "Predictors and Prevention of Non-Fatal Overdose Among Street-Recruited Heroin Users in the San Francisco Bay Area, 1998-1999." *American Journal of Public Health* 1842 (2001): 91.

[61] K.A. Sporer, A. H. Kral, "Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention," *Annals of Emergency Medicine* 49 (2007): 172-77.

[62] "UNM Study Shows Promising Results of MDC's Methadone Treatment Program," *UNM Newsroom* February 4, 2014, accessed on June 4, 2015, http://news.unm.edu/news/unm-study-shows-promising-results-of-mdcs-methadone-treatment-program.

[63] T.C. Green, et al., "Development of an Incarceration-Specific Overdose Prevention Video: *Staying Alive on the Outside*," *Health Education Journal* (2014); *Staying Alive on the Outside* can be accessed at www.prisonerhealth.org.

[64] See, for example, H. Matusow, et al., "Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes," *Journal of Substance Abuse Treatment* 44, 5 (2012); and Colleen O'Donnell and Marcia Trick, *Methadone Maintenance Treatment and the Criminal Justice System* 4, (2006), 11-12; Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System* (2011), accessed May 28, 2015, http://lac.org/wpcontent/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[65] "Advocates Help New Moms in Methadone Treatment Fight Child Protective Services," Addiction Treatment Forum, August 19, 2011, accessed June 4, 2015, http://atforum.com/2011/08/advocates-help-new-moms-in-methadone-treatment/., Rachel Blustain, "Medical Consensus or Child Abuse? Moms on Methadone Caught in the Middle," *Daily Beast*, September 2, 2012, accessed June 4, 2015, http://www.thedailybeast.com/articles/2012/09/02/medical-consensus-or-child-abuse-moms-on-methadone-caught-in-the-middle.html.; National Advocates for Pregnant Woman, "Methadone Treatment, Pregnancy and Legal Issues: What the Experts Have to Say," September 22, 2010, accessed June 4, 2015, http://advocatesforpregnantwomen.org/main/events/new_2010_continuing_education_programing/press_release_methadone_treatment_pregnancy_and_legal_issues_what_the_experts_have_to_say_1.php.

[66] Ryan Grim and Jason Cherkis, "Federal Government Set To Crack Down On Drug Courts That Fail Addicts," *Huffington Post*, February 6, 2015, accessed June 4, 2015, http://www.huffingtonpost.com/2015/02/05/drug-courts-suboxone_n_6625864.html.; Substance Abuse and Mental Health Services Administration, "Grant Announcements: Grants to Expand Substance Abuse Treatment Capacity in Adult and Family Drug Courts," January 26, 2015, accessed June 4, 2015, http://www.samhsa.gov/grants/grant-announcements/ti-15-002.

[67] The Defender Association, "Law Enforcement Assisted Diversion (L.E.A.D.): A Pre-Booking Diversion Model for Low-Level Drug Offenses," (2010).

[68] N = 61 between 2007 and 2011

[69] New Mexico Substance Abuse Epidemiology Profile, Substance Abuse Epidemiology Program Injury and Behavioral Epidemiology Bureau Epidemiology and Response Division.
New Mexico Department of Health, 2011

[70] Federal Bureau of Investigation, 2011

[71] City of Santa Fe's Police Department Statistics, 2011 & 2012

[72] This conservative estimate does not include the additional burden including the loss of productivity and earnings in the economy and cost on social support systems. Many in Santa Fe recognized that this was just a fraction of the costs involved in an opioid-related case. The estimate also does not include ad hoc costs such as drug treatment, public safety and health issues, witness or jury costs, property crime investigation and value of property lost.

[73] Seattle Police Department, "Reported Part II Offenses in Seattle, from 2008," (2013), accessed June 3, 2015, http://www.seattle.gov/police/crime/13_Stats/2013_Part_2_Offenses.pdf, and Ty Swenson, "King County Jail Population Drops Significantly over 13 Years," *West Seattle Herald*, September 4, 2013; and King County Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division, "Impact of DCHS-Supported Programs on Jail Use," (Seattle: King County Department of Community and Human Services, 2013), accessed June 3, 2015, http://www.kingcounty.gov/~/media/health/MHSA/documents/Criminal%20Justice%20documents/130430_Jail_ADP_contributing_factors_revFINAL_04-2013.ashx?la=en.

[74] Susan E. Collins, Heather S. Lonczak, and Seema L. Clifasefi, *LEAD Program Evaluation: Recidivism Report* (University of Washington Harborview Medical Center, 2015), http://static1.1.sqspcdn.com/static/f/1185392/26121870/1428513375150/LEAD_EVALUATION_4-7-15.pdf?token=%2BraNEWghU5FdJPcf8VP1Xlhm63hI%3D.

[75] Susan E. Collins, Heather S. Lonczak, and Seema L. Clifasefi, *LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs* (University of Washington Harborview Medical Center, 2015).

[76] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, *Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths* (2015), http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/ib_OpioidInitiative.pdf; and HHS Office of the Assistant Secretary for Planning and Evaluation, *Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths* (2015), http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_OpioidInitiative.pdf.

[77] Office of National Drug Control Policy, *National Drug Control Strategy: 2014* (Washington, D.C.: Executive Office of the President of the United States, 2014), 3, 77-78, https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf.

Mr. SENSENBRENNER. I now recognize the Chairman of the full Committee, the gentleman from Virginia, Mr. Goodlatte, for his opening statement.

Mr. GOODLATTE. Thank you, Chairman Sensenbrenner.

I am pleased to be here today at this important hearing to examine the growing epidemic of heroin abuse in our Nation.

Over the past several months, we have seen an alarming increase in both the availability and use of heroin. This has, not surprisingly, had profound and tragic consequences. Every day, it seems, brings new stories of overdose deaths occurring across the country, including in my district. Since January, there have been 11 heroin-related overdoses in the Roanoke Valley, resulting in nine deaths.

Earlier this year, the Washington Post reported that the legalization and subsequent availability of high-grade marijuana to American consumers has led Mexican drug cartels to increase the amounts of heroin and methamphetamine they are trafficking across the U.S.-Mexico border. Since 2009, heroin seizures along the border have nearly tripled, as law enforcement seized 2,181 kilograms of Mexican heroin last year alone.

These are alarming statistics. However, the grim reality is that they should surprise no one. Drug trafficking is an extremely profitable business, run by criminals who are interested in one thing: money. Given the increasing availability of marijuana in the United States, and the related, ongoing epidemic of heroin use, drug traffickers have decided to cash in on the misery of American citizens.

Additionally, the Drug Enforcement Administration estimates that the United States has 600,000 heroin users, which is three times the number in 2012. Tragically, that number is expected to rise. That is because there are an estimated 10 million Americans who are currently addicted to prescription opioids, including such drugs as Vicodin, OxyContin, and Percocet. Once someone is addicted to a prescription opioid, the need to satisfy their addiction outweighs the stigma attached to heroin use. Additionally, it is far easier to pay $10 for a dose of heroin than $80 for an oxycodone tablet.

It is no exaggeration to say that heroin use has reached epidemic levels across this Nation, including in my home state of Virginia. It is not an urban problem or a rural problem, but an American public health and safety problem.

However, despite the increase in heroin and meth production, despite the ongoing heroin epidemic, despite the dramatic surge in deaths, and despite the clear evidence that illicit controlled substances and their purveyors pose a lethal threat to the American people, the Obama administration has continued to shirk its duty to protect this Nation from dangerous narcotics.

I firmly believe any solution to the heroin epidemic must have three parts: one, discouraging the use of this dangerous, highly addictive drug; two, providing appropriate treatment to addicts; and three, ensuring law enforcement zealously pursues the criminals who bring this poison into our communities.

I look forward to the witnesses' testimony today.

Mr. SENSENBRENNER. Without objection, all Members' opening statements will appear in the record at this point.

We have a very distinguished panel today, and I will begin by swearing in our witnesses before introducing them. If you would, please, all rise.

Do you solemnly swear that the testimony you are about to give to this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record reflect that all of the witnesses responded in the affirmative.

The gentleman from Virginia, Mr. Forbes, has a distinguished witness, and I will allow him to introduce Commonwealth Attorney Parr at this point, and then I will introduce the next three witnesses.

Mr. FORBES. Thank you, Chairman Sensenbrenner, for holding this important hearing today and inviting our distinguished guests to share their experiences.

As you mentioned, one of our witnesses today is Nancy Parr, who served as the Commonwealth Attorney for the City of Chesapeake since being first elected in November 2005. During her 10 years of service, she has implemented new programs and promoted community outreach, in addition to carrying out the traditional role of a prosecutor's office in Chesapeake. Her programs include seven Girls Empowerment conferences, four Boys Leadership conferences, seven Traveling the Road to Success multi-week programs, and five Playing on the Right Team basketball tournaments.

Prior to her current role, Ms. Parr was a prosecutor in Suffolk for 10 years and before that had worked in Chesapeake since 1994. For six of those years, she also served as a Special Assistant United States Attorney in the Eastern District of Virginia.

In addition to her public service, Ms. Parr is a member of many boards and organizations and volunteers her time to charitable organizations, including the Virginia Association of Commonwealth Attorneys, where she was president from 2014 to 2015; Commonwealth's Attorney Service Council, where she was chairman from 2014 to 2015; State Crime Commission Governor's Task Force on Prescription Drug and Heroin Abuse; Secure Commonwealth Panel Subcommittee, Justice Reinvestment Initiative Work Group; Board of Correctional Education; Virginia State Bar Council; Board of Governors for the Criminal Law Section of Virginia State Bar; Virginia's Adult Fatality Review Team; State Child Fatality Review Team; Domestic Violence Advisory Committee; Boys and Girls Clubs of Southeast Virginia Chesapeake Division; and the Women's Club of South Norfolk.

Ms. Parr is a graduate from the University of Virginia with high distinction, and from T.C. Williams School of Law at the University of Richmond.

Ms. Parr, thank you for accepting our invitation today, and I look forward to hearing your testimony as you share with the Committee more about the efforts you are championing in our district and my home town.

And with that, I will yield to Chairman Sensenbrenner to introduce our other witnesses.

Mr. SENSENBRENNER. Thank you very much, Mr. Forbes.

First, Mr. Michael Botticelli is the Director of the National Drug Control Policy, where he has served since November of 2012. Previously, Mr. Botticelli served as Director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health. He holds a Bachelor of Arts degree from Siena College and a Master's in Education from St. Lawrence University.

Mr. Jack Riley is the Acting Deputy Administrator of the Drug Enforcement Administration. He is the highest ranking career special agent at the DEA. Prior to his appointment as the Chief of Operations, Mr. Riley served in many other leadership positions during his distinguished career at the DEA. He received a Bachelor of Science degree in Criminal Justice from Bradley University and a Master's degree in Public Policy Administration from the University of Illinois.

Ms. Angela Pacheco was the first woman elected to the First Judicial District Attorney's Office. Her legal career has consisted primarily of criminal prosecution in which she has tried a number of high-profile cases. Prior to becoming an attorney, Ms. Pacheco worked as a social worker for 13 years in Northern New Mexico. She received a Bachelor of Arts in Social Work from the College of Santa Fe, and her Juris Doctorate from the Hamline University School of Law.

I would ask each of you to summarize your testimony. Without objection, the witnesses' written statements will be entered into the record in their entirety.

You have something with a red, yellow, and green light in front of each of you. I assume that you know what all of that means.

So, Mr. Botticelli, you are first.

TESTIMONY OF THE HONORBLE MICHAEL P. BOTTICELLI, DIRECTOR, WHITE HOUSE OFFICE OF NATIONAL DRUG POLICY CENTER

Mr. BOTTICELLI. Chairman Sensenbrenner, Chairman Goodlatte, Representative Chu, and Members of the Subcommittee, thank you for the opportunity to be here today to discuss the Administration's response to the epidemic of opioid abuse, particularly the rise in heroin use and overdose deaths.

ONDCP produces the National Drug Control Strategy, which is the Administration's primary blueprint for drug policy. The Strategy treats our Nation's substance use problem as public health challenges, not just criminal justice issues.

The stark increase in the number of people using heroin in recent years has become a significant public health issue in our country, and opioid misuse can have devastating consequences. As we heard, overdose deaths involving heroin have increased sharply in recent years. Of the 44,000 drug overdose deaths in 2013, heroin was involved in over 8,200, up from 5,900 in 2012.

As communities and law enforcement struggle with an increased number of overdose deaths, heroin use and increasing heroin trafficking, it is important to note that the vast over-prescribing of prescription drugs and easy access to diverted opioids is fueling our opioid drug use problem.

Approximately 18 billion opioid pills were dispensed in 2012. This is enough to give every American 18 years and older 75 pain

pills. Even though data indicate that over 95 percent of prescription opioid users do not initiate heroin use, four out of five new users of heroin have used prescription drugs non-medically. Given this relationship, we cannot develop a public health response to heroin use without making it part of a response to prescription opioid use.

While heroin is traditionally regarded as an issue facing large urban areas, we are seeing a shift in the demographic of heroin use. Increasingly, heroin use overdose deaths and their consequences are being seen in suburban and small-town America. A recent CDC study shows that heroin use rates remain highest among males, but heroin use is doubling among women and has more than doubled among non-Hispanic Whites.

We also know from this same study that past-year alcohol, marijuana, cocaine, and opiate pain reliever misuse or dependence were each significant risk factors for heroin abuse or dependence.

ONDCP has used its role as coordinator of the Federal drug control agencies to bolster support for substance use disorder treatment and overdose prevention efforts and coordinate a government-wide response. In 2011, the Administration's plan to address the sharp rise in prescription opioid drug misuse was released. This plan contains action items categorized in four categories: education of prescribers and patients; increased drug monitoring programs; proper medication disposal; and law enforcement efforts.

Recently, the Administration convened the Congressionally-mandated Interagency Heroin Task Force, co-chaired by ONDCP and the Department of Justice, to more closely examine the Administration's efforts and to devise recommendations in what more we can do.

We have seen overdose from prescription opioid leveling off, but unfortunately this is coupled with a dramatic 39 percent increase in heroin-involved overdose deaths from 2012 to 2013. To address the overdose death issue, we have been working to increase access to naloxone for first responders and individuals close to those with opioid drug use disorders. Hand in hand with these efforts are efforts to promote Good Samaritan laws so witnesses to an overdose will take steps to help save lives.

Law enforcement nationwide has risen to this challenge of the increase in opioid use and overdose deaths. They are working hand in hand with members of the public health community. But it is critically important for the medical establishment to work with us to meet the challenges of increasing access to treatment for individuals with opioid use disorders. Primary care physicians have an opportunity for early intervention, as do emergency department physicians, to treat substance use disorders early and to intervene before they become chronic. And it is vital that individuals with opioid use disorders receive evidence-based care and treatment. Medication-assisted treatment with FDA-approved medications, when combined with behavioral therapies and recovery, has shown to be the most effective treatment for opioid use disorders. Just this weekend, Secretary Burwell announced an additional $33 million in funding to states to expand the use of medication-assisted treatment, and an additional $100 million to fund improved access to care and services at community health centers nationwide.

HHS is also releasing guidance to states to help implement innovative approaches to substance use disorder treatments. The Administration has also proposed $99 million in the Fiscal Year 2016 budget request over Fiscal Year 2015 for treatment and overdose prevention efforts.

In addition, given the connection between injection opioid drugs and infectious disease transmission, public health strategies are necessary to prevent the further spread of infectious disease. The recent HIV and hepatitis C outbreak in Indiana is a stark reminder of how opioid abuse can spread other diseases, how comprehensive public health measures such as syringe services programs need to be part of the response, and how rural communities with limited treatment capacity may experience additional public health crises.

In conclusion, we will continue to work with Congress and our Federal partners on the public health and public safety issues resulting from the epidemic of non-medical prescription opioid use and heroin use. Thank you for your time.

[The prepared statement of Mr. Botticelli follows:]

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

"The Public Health Implications of Heroin and the Federal Response to the Opioid Overdose Epidemic"

Tuesday July 28, 2015
10:00 a.m.
2141 Rayburn House Office Building

Statement of
Michael P. Botticelli
Director of National Drug Control Policy

Chairman Sensenbrenner, Ranking Member Jackson Lee, and members of the Subcommittee, thank you for this opportunity to address the public health issues surrounding heroin in the United States and the Federal response.

As you know, the Office of National Drug Control Policy (ONDCP) was established in 1988 by Congress with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. As a component of the Executive Office of the President, our office establishes policies, priorities, and objectives for the Nation's drug control programs and ensures that adequate resources are provided to implement them. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and ensure such efforts sustain and complement state and local drug policy activities.

At ONDCP, we are charged with producing the *National Drug Control Strategy* (*Strategy*), the Administration's primary blueprint for drug policy, along with a national drug control budget. The *Strategy* is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation's drug problem as a public health challenge, not just a criminal justice issue. It is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America.

The considerable public health and safety consequences of nonmedical prescription opioid and heroin use underscore the need for action. Since the Administration's inaugural 2010 *National Drug Control Strategy*, we have deployed a comprehensive and evidence-based strategy to address opioid use disorders and overdose deaths due to heroin use and prescription opioid misuse. The Administration has increased access to treatment for substance use disorders, expanded efforts to prevent overdose and has coordinated a Government-wide response to the consequences of nonmedical prescription drug use. We also have continued to pursue actions against criminal organizations trafficking in opioid drugs. This statement focuses largely on the Administration's public health policy interventions to address opioid drug abuse, as well as those of our Federal, state and local partners, including professional associations that are involved with opioid prescribing or the prevention and treatment of opioid misuse. The statement of the Drug Enforcement Administration (DEA) for this hearing will discuss supply and law enforcement approaches.

Trends and Consequences of Opioid Use

Opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone and hydrocodone – are having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention (CDC), approximately 120 Americans on average died from a drug overdose every day in 2013. Of the nearly 44,000 drug overdose deaths in 2013, opioid pain relievers were involved in over 16,200, while heroin was involved in over 8,200. Overall, drug overdose deaths now outnumber deaths from gunshot wounds (over 33,600) or motor vehicle crashes (over

32,700)[1] in the United States.[2] Moreover, overdose deaths related to opioid pain relievers and heroin are undercounted as around one quarter of death certificates do not list the drug responsible for the fatal drug overdose,[3] and until recently standards did not exist for death investigation reporting, and adoption of these standard is not universally practiced.[4]

The diversion and nonmedical use of prescription opioid medications has been of serious concern at the national, state, and local levels for over a decade. Increases in admissions to treatment for substance use disorders,[5] drug-related emergency department visits,[6] and, most disturbingly, overdose deaths[7] attributable to nonmedical prescription drug use place enormous burdens upon communities across the country. Heroin, in contrast, until very recently has been used at much lower rates, possibly because historically its use was generally via injection, which often was necessitated by its low purity. As heroin purity increases, heroin can be smoked or snorted.[8] Research shows that price reductions (resulting from greater availability) are closely related to overdose hospitalization rates; every $100 decrease in the price of heroin per pure gram results in a 2.9 percent increase in the number of overdose hospitalizations.[9]

In 2013, over 4.5 million Americans ages 12 and older reported using prescription pain relievers non-medically within the past month.[10] This makes nonmedical prescription pain reliever use more common than use of any category of illicit drug in the United States except for marijuana. Approximately 289,000 Americans reported past month use of heroin in 2013.[11] Heroin use remains relatively low in the United States when compared to other drugs; however, the increase in the number of people using the drug in recent years – from 373,000 past year users in 2007 to 681,000 in 2013 – is troubling.[12] These figures likely undercount the number of users, as national household surveys do not track all heroin-using populations such as homeless users. At least one community with a high level of chronic drug users among its homeless

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

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

[3] See http://s3.documentcloud.org/documents/1151267/heroin-project-2014-study-on-overdose-deaths.pdf

[4] Goldberger BA1, Maxwell JC, Campbell A, Wilford BB. Uniform standards and case definitions for classifying opioid-related deaths: recommendations by a SAMHSA consensus panel. J Addict Dis. 2013;32(3):231-43. doi: 10.1080/10550887.2013.824334.

[5] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) 2001-2011, National Admissions to Substance Abuse Treatment Services*. U.S. Department of Health and Human Services. [2013]. Extracted April 2013.

[6] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2

[7] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015.

[8] Stöver HJ1, Schäffer D. SMOKE IT! Promoting a change of opiate consumption pattern - from injecting to inhaling. Harm Reduct J. 2014 Jun 27;11:18. doi: 10.1186/1477-7517-11-18. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4094754/

[9] Unick GJ, Rosenblum D, Mars S, Ciccarone D.Addiction. The relationship between US heroin market dynamics and heroin-related overdose, 1992-2008.2014 Nov;109(11):1889-98. doi: 10.1111/add.12664. Epub 2014 Aug 4.

[10] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3b

[11] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3A

[12] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.2A

population, Baltimore, revises their heroin count by 10 percent to adjust for heroin use among its homeless population.[13]

Nonetheless, the trend for increases in heroin users shown in the National Survey on Drug Use and Health (NSDUH), a household-based survey from the Substance Abuse and Mental Health Services Administration (SAMHSA), comports with other indicators, including recent reporting from the National Institute on Drug Abuse's (NIDA) Community Epidemiology Work Group, which found that a number of U.S. cities, including Atlanta, Baltimore, Boston, Chicago, Cincinnati, Denver, Miami, Minneapolis, San Diego, Seattle, and St. Louis, indicated increases in heroin use. In addition, heroin remained at relatively stable but high levels in Detroit, New York City, and Philadelphia.[14] DEA also reports an over 300 percent increase of heroin seizures at the Southwest border from 2008 to 2013.[15]

A recent report from CDC and FDA using NSDUH public-use data[16] shows a significant increase in heroin use from 2002 to 2004 and from 2011 to 2013. Rates remained highest among males, persons aged 18 to 25 years, persons with annual household incomes below $20,000, persons living in urban areas, and persons with no health insurance or with Medicaid; however, rates increased significantly across almost all study groups. Moreover, the greatest increases in heroin use occurred in demographic groups that historically have had lower rates of heroin use, doubling among women and more than doubling among non-Hispanic whites. The rates of individuals who developed abuse or dependence on heroin, a near doubling during the decade-long study period, with a 35.7 percent increase during 2008–2010 alone, emphasize the addictive nature of this drug. This increase parallels the sharp increase in heroin-related overdose deaths reported since 2010.

This report also indicates that individuals who use heroin also use other drugs. People with past year abuse of or dependence on alcohol, marijuana, cocaine, or opioid pain relievers were at increased risk for past year heroin abuse or dependence. In 2013, 59 percent of the 8,257 heroin-related overdose deaths in the United States involved at least one other drug.[17] Data presented in this report indicate the relationship between heroin and opioid pain relievers, as well as the relationship between heroin and cocaine, are particularly strong. In fact, past year abuse or dependence on opioid pain relievers was the strongest risk factor for past year heroin abuse or dependence. These results, coupled with prior research on heroin use trajectories, underscore that heroin use has its roots in, and often exists alongside, other forms of substance misuse.

Research illustrates that heroin use today is one of the later steps in most personal drug use trajectories. An analysis of NSDUH data shows that 21,000 people nationally began using

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[13] Baltimore Mayor's Heroin Treatment & Prevention Task Force Report http://health.baltimorecity.gov/sites/default/files/Mayor%20Heroin%20Treatment%20Prevention%20Task%20Force%20Final%20Report%20July%2013%202015.pdf

[14] National Institute on Drug Abuse. Highlights and Summaries from January 2014 Reports. Available: http://www.drugabuse.gov/about-nida/organization/workgroups-interest-groups-consortia/community-epidemiology-work-group-cewg/highlights-summaries-january-2014-reports

[15] National Seizure System, El Paso Intelligence Center, extracted January 25, 2014.

[16] Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25 Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w

[17] CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2014. Available at http://wonder.cdc.gov.

heroin when 12 to 17 years old, 66,000 people began using when 18 to 25 years old, and 82,000 began when 26 years and older.[18] Past-year heroin users were most likely to be in the 26 and older demographic. A second study of treatment seekers found the average age of treatment seekers to be around 23, and 75 percent of these began by using prescription opioids first.[19] While the increases in overdose deaths among young people is disturbing, and pediatricians and doctors caring for people under the age of 25 need to be engaged on this issue, practitioners who treat adults normally past the typical age for developing substance use disorders need to monitor their patients for possible heroin use.

The nonmedical use of opioids translates into serious health consequences. In 2013 alone, approximately 1.9 million Americans met the diagnostic criteria for abuse of or dependence on prescription pain relievers, with heroin accounting for approximately 517,000 people with past-year abuse or dependence; both figures represent significant increases from just a decade earlier.[20] For the duration of this statement, the terms "opioid use disorder" and "heroin use disorder" will be used to describe people who meet the criteria for abuse and dependence, since the terminology in the Diagnostic and Statistical Manual, Fifth Edition (DSM 5), the U.S. standard for classifying mental health disorders, no longer makes a distinction between abuse and dependence.

Although only about 15 percent of people who have not used heroin in the past year believe it would be fairly or very easy to obtain, approximately 81 percent of people who have used it in the past year hold that belief.[21] Most Americans of all ages perceive great risk in using heroin once or twice a week.[22] Disturbingly, approximately 20 percent of people 12 to 17 years old do not believe using heroin once or twice weekly is harmful (compared to only 5 percent of people 26 or older).[23]

Beyond the many lives taken by fatal overdoses involving these medications, prescription opioids are associated with significant burden on our healthcare system. In 2011 alone, the last year for which these data are available, 1.2 million emergency department (ED) visits involved the nonmedical use of prescription drugs.[24] Of these 1.2 million ED visits, opioid pain relievers accounted for the single largest drug class, accounting for approximately 488,000 visits. This is nearly triple (2.8 times) the number of ED visits involving opioid pain relievers just 7 years

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[18] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.

[19] Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. JAMA Psychiatry. 2014 Jul 1;71(7):821-6. doi: 10.1001/jamapsychiatry.2014.366. PMID: 24871348 available at http://archpsyc.jamanetwork.com/article.aspx?articleid=1874575

[20] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.40A

[21] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.

[22] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.

[23] *Ibid.*

[24] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2

earlier in 2004 (173,000). Among specific opioid drugs in 2011, oxycodone accounted for the largest share (31%) of ED visits; there were 100,000 more visits involving oxycodone in 2011 than in 2004, an increase of 263 percent. Heroin was involved in nearly 258,000 visits in 2011. Increases in hospitalizations for prescription opioid overdose within a community actually predicts subsequent year heroin overdose,[25] indicating that not only do people tend to migrate to heroin if it is available, but also entire communities may shift usage habits.

Similar trends concerning growth in heroin use are reflected in the country's specialty substance use disorder treatment system. Data show a more than double increase in the past ten years of treatment admissions for individuals primarily seeking treatment for prescription opioid use disorder, from 53,000 in 2003 to 127,000 in 2011. Heroin treatment admissions remained flat over the same time period, yet accounted for 285,451 admissions in 2012.[26] Although all states have not yet reported specialty treatment admission data for 2013 and 2014, the trend in those states that have is that many more people are seeking treatment for heroin use than in the past.[27] In contrast, the percentage of people seeking treatment for prescription opioid use disorder has declined. Not every state, however, has experienced this decline. In some states with particularly intransigent prescription opioid misuse problems (for example, Tennessee), treatment admissions remain higher. In some states with historically high heroin treatment admissions (for example, New York), prescription opioid treatment admissions began an upward climb only in the late 1990s and at much lower levels.

There has been considerable discussion around potential connections between the non-medical use of prescription opioids and heroin use. There is evidence to suggest that some users, specifically those with a serious prescription opioid use disorder, will substitute heroin for prescription opioids. Heroin is cheaper than prescription opioids. A SAMHSA report found that four out of five recent heroin initiates had previously used prescription pain relievers nonmedically. However, only a very small proportion (3.6%) of those who recently had started using prescription drugs nonmedically initiated heroin use in the following five-year period.[28] Preventing the initiation of nonmedical opioid use nevertheless can help reduce the pool of people who may resort to heroin initiation later on because a large proportion of heroin users begin with abusing opioid pain relievers, even if this is a small subset of overall nonmedical opioid users.

We also know that substance use is often progressive, with some users rapidly escalating their use frequency, dosing, potency of drug and using through routes other than oral administration (e.g., sniffing, smoking or injecting) to achieve greater euphoria. Because the body rapidly develops tolerance to most effects of opioids and because withdrawal from opioids

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[25] Unick GJ, Rosenblum D, Mars S, Ciccarone D. Intertwined epidemics: national demographic trends in hospitalizations for heroin- and opioid-related overdoses, 1993-2009. PLoS One. 2013;8(2):e54496. doi: 10.1371/journal.pone.0054496. Epub 2013 Feb 6. PMID: 23405084.

[26] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment Admissions by Primary Substance of Abuse, United States* [2002 through 2012 – Table 1.1a]. U.S. Department of Health and Human Services. [July 2014]. Available:
http://www.samhsa.gov/data/sites/default/files/2002_2012_TEDS_National/2002_2012_Treatment_Episode_Data_Set_National_Tables.htm

[27] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment extracted 6/2/2015 (Source Cala TIC Presentation Primary Drug Treatment Admissions.*

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

exerts the opposite effect (e.g., severe pain and gastrointestinal distress) regardless of whether the drug used is a relatively weak opioid like codeine or a stronger one like heroin, a vicious cycle can develop, where a user must keep using to avoid the severe flulike and depressive symptoms associated with withdrawal. We know from survey data that as an individual's nonmedical use of prescription opioids becomes more frequent or chronic, that person is more inclined to purchase the drugs from dealers/prescriptions from multiple doctors, rather than simply getting them for free from a friend or relative.[29] Qualitative data indicates as tolerance, dependence, or craving increases, users tend to obtain more opioid sources and at times will select lower cost alternatives such as heroin as a way to meet and afford escalating opioid needs.[30,31,32] Research also suggests that the same dealers who deal in illicit pills often also supply heroin.[33]

The Administration's Response

Since 2009, the Obama Administration has deployed a comprehensive and evidence-based strategy to address: (1) excessive and dangerous opioid prescribing for pain and its consequences; and (2) illegal importation and sales of heroin. These efforts have expanded as surveillance has revealed an uptick in deaths related to the laboratory-created synthetic drug fentanyl and its analogs.

The following discussion identifies the efforts in each of these areas as experts believe they are all important for addressing heroin and the public health of people and communities heroin impacts.

Efforts to Stem the Prescription Opioid Crisis

President Obama's inaugural *National Drug Control Strategy*, released in May 2010, labeled opioid overdose a "growing national crisis" and laid out specific actions and goals for reducing nonmedical prescription opioid and heroin use.[34]

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[29] Unpublished estimates from Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*, 2009-2012, March 2014.

[30] Lankenau SE, Teti M, Silva K, Jackson Bloom J, Harocopos A, Treese M. Initiation into prescription opioid misuse amongst young injection drug users. Int J Drug Policy. 2012 Jan;23(1):37-44. doi: 10.1016/j.drugpo.2011.05.014. Epub 2011 Jun 20. PMID: 21689917 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196821/

[31] Lankenau SE1, Teti M, Silva K, Bloom JJ, Harocopos A, Treese M.J Patterns of prescription drug misuse among young injection drug users.Urban Health. 2012 Dec;89(6):1004-16. doi: 10.1007/s11524-012-9691-9. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3531346/

[32] Sarah G. Mars, Philippe Bourgois, George Karandinos, Fernando Montero, Daniel Ciccarone. "Every 'Never' I Ever Said Came True": Transitions from opioid pills to heroin injecting Int J Drug Policy. Author manuscript; available in PMC 2015 March 1.Published in final edited form as: Int J Drug Policy. 2014 March; 25(2): 257–266. Published online 2013 October 19. doi: 10.1016/j.drugpo.2013.10.004 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/pdf/nihms533727.pdf

[33] Sarah G. Mars, Philippe Bourgois, George Karandinos, Fernando Montero, Daniel Ciccarone. "Every 'Never' I Ever Said Came True": Transitions from opioid pills to heroin injecting Int J Drug Policy. Author manuscript; available in PMC 2015 March 1.Published in final edited form as: Int J Drug Policy. 2014 March; 25(2): 257–266. Published online 2013 October 19. doi: 10.1016/j.drugpo.2013.10.004 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/pdf/nihms533727.pdf

[34] Office of National Drug Control Policy. *2010 National Drug Control Strategy*. Executive Office of the President. [2010]. Available: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010.pdf?page=49

Nonmedical use of prescription drugs still represents the bulk of illicit opioid use in America, and pharmaceutical opioids are responsible for the majority of opioid-related deaths. Our response to this public health emergency focuses on preventing the diversion and nonmedical use of prescription drugs, decreasing the number of Americans dying from opioid overdose every day, and expanding access to effective treatment, health care, and services for people with opioid use disorders.

In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)*,[35] which created a national framework for reducing prescription drug diversion and misuse. The *Plan* focuses on: improving education for patients and healthcare providers; supporting the expansion of state-based prescription drug monitoring programs; developing more convenient and environmentally responsible disposal methods to remove unused and unneeded medications from the home; and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts.

The Administration has made considerable progress in all four areas of the *Plan*. To start, much progress has been made in expanding available continuing education for prescribers. Managing patients' pain is a crucial area of clinical practice, but research indicates that health care practitioners receive little training on pain management or, safe opioid prescribing.[36,37] Ten states (Connecticut,[38] Delaware,[39] Iowa,[40] Kentucky,[41] Massachusetts,[42] New Mexico,[43] Ohio,[44] Tennessee,[45] Utah,[46] and West Virginia[47]) have passed legislation mandating education for prescribers, and we strongly encourage other states to explore this as an option.

At the Federal level, the Department of Health and Human Services (HHS) has implemented education requirements for its agency health care personnel, including professionals serving tribal communities through the Indian Health Service (IHS), those working with underserved populations through the Health Resources and Services Administration (HRSA), and personnel attending to biomedical research trial participants at the Clinical Center of the National Institutes of Health (NIH). Similar efforts have been implemented by the Bureau of Prisons and the Department of Defense (DoD). The Department of Veterans Affairs (VA) is making training available to clinicians although it is not currently required.

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[35] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis* [2011] Available: http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf

[36] Mezei, L., et al. Pain Education in North American Medical Schools. *The Journal of Pain.* 12(12):1199-1208. 2011.

[37] U.S. Government Accountability Office. *Prescription Pain Reliever Abuse.* [December 2011]. Available: http://www.gao.gov/assets/590/587301.pdf

[38] CONN. GEN. STAT. § 20-10b (2015), *available at* http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm

[39] 24 DEL. CODE ANN. § 3.1.1, *available at* http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.pdf.

[40] IOWA ADMIN. CODE r. 253-11.4 (2011), *available at* https://www.legis.iowa.gov/docs/ACO/chapter/07-22-2015.653.11.pdf.

[41] 201 Ky. Admin. Reg. 9:250 (2013), *available at* http://www.lrc.ky.gov/kar/201/009/250.htm.

[42] MASS. GEN. LAWS ch. 94C, § 18(e) (2011), *available at* https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c/Section18.

[43] N.M. ADMIN. CODE § 16-10-14 (2012), *available at* http://164.64.110.239/nmac/parts/title16/16.010.0014.htm.

[44] OHIO REV. CODE ANN. § 4723.482

[45] TENN. CODE ANN. § 63-1-402 (2013), *available at* http://www.tn.gov/sos/acts/108/pub/pc0430.pdf.

[46] UTAH ADMIN. CODE r. 58-37-6.5 (2012), *available at* http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5_1800010118000101.

[47] W. VA. CODE § 30-1-7A (2011), *available at* http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=1&section=7A.

The Administration developed and has made available free and low-cost training options available for prescribers and dispensers of opioid medications via several sources, including SAMHSA and NIDA. The Food and Drug Administration (FDA) now requires manufacturers of extended-release and long-acting (ER/LA) opioid pain relievers to make available free or low-cost continuing education to prescribers under the Risk Evaluation and Mitigation Strategy (REMS) for these drugs.

These efforts alone, however, cannot address the dearth of critical and necessary opioid prescriber training as it is an optional program. From 2010 to 2013, overdose deaths involving prescription opioids have decreased – but only by 2 percent.[48] We must do more to ensure all prescribers have the tools they need to prevent nonmedical prescription drug use. The Administration continues to support policies that mandate a continuing education requirement for prescribers, as outlined in the *Plan,* potentially linked to their registration to prescribe with the DEA.

In March, HHS announced a comprehensive, evidence-based initiative aimed at reducing opioid dependence and overdose. Among the three priority areas of the initiative are efforts to train and educate health professionals on safe opioid prescribing, including the development of prescribing guidelines for chronic pain by the CDC.

FDA has also taken a number of steps to help safeguard access to opioid analgesics while reducing risks of non-medical use and overdose. In April 2013, FDA approved updated labeling for reformulated OxyContin that describes the medication's abuse-deterrent properties. These properties are expected to make the drug more difficult to inject or abuse nasally.[49] In September 2013, ONDCP joined the FDA to announce significant new measures to enhance the safe and appropriate use of ER/LA opioid analgesics.[50] FDA required class-wide labeling changes for these medications, including modifications to the products' indication for pain severe enough to require daily, around-the clock, long-term opioid treatment and for which alternative treatment options are inadequate, warnings around use during pregnancy, as well as post-market research requirements. FDA also announced that manufacturers of ER/LA opioids must conduct further studies and clinical trials to better assess risks of misuse, addiction, overdose, and death. And in December 2013, FDA announced its recommendation that DEA reschedule hydrocodone combination products from Schedule III to Schedule II of the Controlled Substances Act; in August 2014, DEA issued a Final Rule implementing this recommendation, which became effective in October 2014.[51]

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

[49] "Determination That the OXYCONTIN (Oxycodone Hydrochloride) Drug Products Covered by New Drug Application 20–553 Were Withdrawn From Sale for Reasons of Safety or Effectiveness." Federal Register 78:75 (April 18, 2013) p. 23273. Available: http://www.gpo.gov/fdsys/pkg/FR-2013-04-18/pdf/2013-09092.pdf

[50] Food and Drug Administration. "ER/LA Opioid Analgesic Class Labeling Changes and Postmarket Requirements Letter to ER/LA opioid application holders." Department of Health and Human Services. [September 2013]. Available: http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM367697.pdf

[51] 21 CFR Part 1308 Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II. DEA. Final Rule. Available at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-19922.pdf

The Administration is also educating the general public about the dangers of opioid use. ONDCP's Drug-Free Communities (DFC) Support Program currently funds 680 community coalitions to work with local youth, parent, business, religious, civic, and other groups to help prevent youth substance use. Grants awarded through the DFC program are intended to support established community-based coalitions capable of effecting community-level change. All DFC-funded grantees are required to collect and report data on past 30-day use; perception of risk or harm of use; perception of parental disapproval of use; and perception of peer disapproval of use for four substances, including prescription drugs.

The second area of the Administration's *Plan* focuses on improving the operations and functionality of state-administered Prescription Drug Monitoring Programs (PDMPs). PDMP data can help prescribers and pharmacists identify patients who may be at-risk for substance use disorders, overdose, or other significant health consequences of misusing prescription opioids. State regulatory and law enforcement agencies may also use this information to identify and prevent unsafe prescribing, doctor shopping, and other methods of diverting controlled substances. Aggregate data from PDMPs can also be used to track the impact of policy changes on prescribing rates. The Prescription Behavior Surveillance System, funded by CDC and FDA, is developing this surveillance capacity for PDMPs. Research also shows that PDMPs may have a role in reducing the rates of prescribing for opioid analgesics. For example, states where PDMPs are administered by a state health department showed especially positive results.[52]

In 2006, only twenty states had PDMPs. Today, the District of Columbia has a law authorizing a PDMP, and forty-nine states have operational programs.[53] The state of Missouri stands alone in not authorizing a PDMP. Kentucky[54], New Jersey,[55] New Mexico[56], New York[57], Oklahoma[58], and Tennessee[59] all require their prescribers to use their state's PDMP prior to prescribing in certain circumstances. In Tennessee, where the requirement to check the PDMP went into effect in 2013, there was a drop in the number of high utilizers of opioid pain relievers from the fourth quarter of 2011 to the fourth quarter of 2013.[60]

Building upon this progress, the HHS Office of the National Coordinator for Health Information Technology (ONC) and SAMHSA are working with state governments and private sector technology experts to integrate PDMPs with health information technology (health IT) systems such as electronic health records. Health IT integration will enable authorized healthcare providers to access PDMP data quickly and easily at the point of care. CDC is evaluating the SAMHSA grantees to identify best practices and determine the impact of the integration efforts.

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[52] Brady, JE., Wunsch, H, Dimaggio, C, Lang, BH, Giglio, J, and Li, G. Prescription drug monitoring and dispensing of prescription opioids. Public Health Reports 2014, 129 (2): 139-47. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904893/pdf/phr129000139.pdf

[53] National Alliance of Model State Drug Laws. (2014). Status of State Prescription Drug Monitoring Programs (PDMPs). Retrieved from http://www.namsdl.org/library/16666FCC-65BE-F4BB-A2BBAD44E1BC7031/.

[54] Kentucky 201 KAR 9:260. 2012. Available at http://www.lrc.ky.gov/kar/201/009/260.htm

[55] P.L. 2015, c.74 (N.J. 2015), *available at* http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF

[56] New Mexico Register. 16.12.9.9. November 15, 2012. Available at http://www.nmcpr.state.nm.us/new-mexico-register/prev_issues/prev_issues/xxiii/xxiii21/16.12.9amend

[57] New York 3343-A. 2012. Available at http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a

[58] Oklahoma 3251. 2010. Available at http://www.oklegislature.gov/cf_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf

[59] Tennessee 2253. 53-10-310. 2012. Available at http://www.tn.gov/sos/acts/107/pub/pc0886.pdf

[60] Tennessee Department of Health Controlled Substance Monitoring Database Committee. Controlled Substance Monitoring Database 2014 Report to the 108th Tennessee General Assembly, February 1, 2014. Page 5. Available at http://health.tn.gov/statistics/Legislative_Reports_PDF/CSMD_AnnualReport_2014.pdf Linked to 9-04-2014

The Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) is also supporting expanded interstate sharing of PDMP data, which is especially important. Currently, at least thirty states have some ability to share data. PDMP administrators are working to better integrate these systems into other health IT programs. In FY 2014, BJA made fifteen site-based awards for states to implement or enhance a PDMP program or strategy to address non-medical prescription drug use, misuse and diversion within their communities. Since inception of the grant program in FY 2002, grants have been awarded to forty-nine states and one U.S. territory. In recent years, the grant program included tribal participation, and gave support to states and localities to expand collaborative efforts between public health and public safety professionals. For example, according to Maryland's Department of Health and Mental Hygiene, [61] the state used its grant funding to form local overdose fatality review (OFR) teams comprised of multi-agency, multi-disciplinary stakeholders who review information on individuals who died from drug and alcohol related overdose. The OFR teams meet monthly to review medical examiner and other data such as substance use disorder treatment records. They identify overdose risk factors, missed opportunities for prevention/intervention, and make policy recommendations. These teams work on both prescription opioid and heroin overdose deaths. Currently the PDMP cannot disclose its information directly to the fatality review teams but there is a proposal to change this law so the review team can request data directly. This is an excellent example of how the PDMP expansion can be useful in understanding and addressing what for some can be the second stage of opioid use disorders, heroin use.

In February 2013, the VA issued an Interim Final Rule authorizing VA physicians to access state PDMPs in accordance with state laws and to develop mechanisms to begin sharing VA prescribing data with state PDMPs. The interim rule became final on March 14, 2014.[62] Since then, the VA has developed and installed software to enable VA pharmacies to transmit their data to PDMPs. As of April 2015, 67 VA facilities were sharing information with PDMPs in their respective states. VA providers have also begun registering and checking the state databases. However, the VA does not currently require prescribers to check the PDMP prior to prescribing.

While PDMP reporting is not required by IHS facilities, many tribes have declared public health emergencies and have elected to participate with the PDMP reporting initiative. Currently, IHS is sharing its pharmacy data with PDMPs in 18 states,[63] and IHS is in the process of negotiating data-sharing with more states.[64] As these systems continue to mature, PDMPs can enable health care providers and law enforcement agencies to prevent the non-medical use and diversion of prescription opioids.

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[61] Maryland Department of Health & Mental Hygiene. (2014). Overdose Fatality Review in Maryland. Harold Rogers PDMP National Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-04_Baier.pdf. Accessed on 4-22-2015.
[62] Disclosures to Participate in State Prescription Drug Monitoring Programs, 78 Fed. Reg. 9589 (Feb. 11, 2013); 79 Fed. Reg. 14400 (Mar. 14, 2014).
[63] Indian Health Service. (2014). Prescription Drug Monitoring Programs: Indian Health Service Update. Harold Rogers PDMP Annual Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-14_Tuttle.pdf.
[64] Cynthia Gunderson, Prescription Drug Monitoring Programs & Indian Health Service, Barriers, Participation, and Future Initiatives, Presentation at Third Party Payer Meeting, December 2012. http://www.pdmpexcellence.org/sites/all/pdfs/Gunderson.pdf.

The third pillar of our *Plan* focuses on safely removing millions of pounds of expired and unneeded medications from circulation. Research shows that approximately 53 percent of past year nonmedical users of prescription pain relievers report getting them for free from a friend or relative the last time they used them, and for approximately 84 percent of these, that friend or relative obtained the pain relievers from one doctor. An additional 15 percent bought or took them from a friend or relative.[65] Safe and proper disposal programs allow individuals to dispose of unneeded or expired medications in a safe, timely, and environmentally responsible manner.

From September 2010 through September 2014, the DEA partnered with hundreds of state and local law enforcement agencies and community coalitions, as well as other Federal agencies, to hold nine National Take-Back Days. Through these events, DEA collected and safely disposed of more than 4.8 million pounds of unneeded or expired medications.[66] DEA has scheduled its next National Take-Back Day for September 26, 2015.

In addition, DEA published a Final Rule for the Disposal of Controlled Substances, which took effect October 9, 2014.[67] These new regulations expand the options available to securely and safely dispose of unneeded prescription medications. They authorize certain DEA registrants (manufacturers, distributors, reverse distributors, narcotic treatment programs, retail pharmacies, and hospitals/clinics with an on-site pharmacy) to modify their registration with the DEA to become authorized collectors. Collectors may operate a collection receptacle at their registered location, and anyone can distribute pre-printed/pre-addressed mail-back packages that go to mail-back program operators. Retail pharmacies and hospitals/clinics with on-site pharmacies and law enforcement to include Veterans Health Administration (VHA) and DoD police officers may operate their own disposal collection receptacles. In addition, long-term care facilities that offer disposal collection receptacles must partner with either a retail pharmacy or a hospital/clinic with an on-site pharmacy to operate collection receptacles in their facilities. Any person or entity may partner with law enforcement to conduct take-back events. Additionally, VHA is offering drug take back options to Veterans.[68]

ONDCP and DEA have engaged with Federal, state, and local agencies, and other stakeholders to increase awareness and educate the public about the new rule. In November 2014, ONDCP, DEA and the Alameda County California Superintendent's office hosted a webinar for community agencies to explain the new rule and discuss how local ordinances might define or fund disposal programs. Over 800 people registered for the program, and 436 viewed it live.[69] ONDCP and DEA will engage with Federal partners as well as with state and local entities to develop and implement a plan to develop disposal programs nationwide.

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[65] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. Department of Health and Human Services. [September 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm#2.16

[66] Drug Enforcement Administration. "DEA and Partners Collect 309 Tons of Pills on Ninth Prescription Drug Take-Back Day." Department of Justice. [November 5, 2014]. Available: http://www.dea.gov/divisions/hq/2014/hq110514.shtml

[67] Disposal of Controlled Substances, 79 Fed. Reg. 53519 (Sep. 9, 2014). Available: https://www.federalregister.gov/articles/2014/09/09/2014-20926/disposal-of-controlled-substances

[68] Veterans Health Administration. "Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans." [August 26, 2014]. Available at: http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf. Accessed on 12-01-2014.

[69] Office of National Drug Control Policy. "Website Blog Watch: Webinar DEA Final Rule on Disposal of Controlled Substances." Available at: https://www.whitehouse.gov/blog/2014/11/17/watch-webinar-dea-s-final-rule-disposal-control-substances. Accessed on 4-15-2015

The *Plan's* fourth pillar focuses on improving law enforcement capabilities to reduce the diversion of prescription opioids. Federal law enforcement, to include our partners at DEA, is working with state and local agencies across the country to reduce pill mills, prosecute those responsible for improper or illegal prescribing practices, and make it harder for unscrupulous registrants including pharmacies to remain in business. An unintended consequence of law enforcement efforts against pharmaceutical suppliers can occur when major enforcement actions happen, patients receiving medicines for legitimate conditions from those providers or pharmacies may be abandoned. Without being tapered off their opioid regimens they will experience withdrawal which can be profoundly disabling and is only alleviated by an opioid.[70] It is not known how many patients have resorted to heroin in these circumstances, but without coordination between law enforcement to ensure enforcement activities do not interrupt legitimate patient care, we are concerned about unintended consequences.

All of these efforts under the *Prescription Drug Abuse Prevention Plan* are intended to reduce the diversion, non-medical use, and health and safety consequences of prescription opioids. The Administration has worked tirelessly to address the problem at the source and at an array of intervention points. This work has been paralleled by efforts to address heroin trafficking and use, as well as the larger opioid overdose problem facing this country.

Efforts to Stem the Heroin Crisis:

Heroin was added to Schedule I of the controlled substances list in 1914, and efforts to address heroin use and trafficking have been reflected annually in our *National Drug Control Strategy*. Opium poppy, from which heroin is derived, is not grown in the United States, and manufacturing is based outside of the country, primarily in Mexico for U.S. sales. Drug seizure data suggest a great deal of heroin has been flowing into the United States in recent years, primarily from Mexico but also from South America.

Pharmaceutical opioids activate the same receptors in the brain as heroin, a reason why users can switch from one to the other and avoid withdrawal. Approximately 18 billion opioid pills were dispensed in 2012,[71] enough to give every American 18 years or older 75 pills.[72] Plentiful access to opioid drugs via medical prescribing and easy access to diverted opioids for nonmedical use help feed our opioid crisis. In fact, as discussed above, the majority of new users come to heroin with experience as nonmedical prescription drug users.[73] Prior to today's opioid epidemic, heroin largely had been confined to urban centers with larger heroin using populations. Many communities and states that have never had a heroin use problem are now dealing with this epidemic, as Vermont Governor Shumlin discussed in his 2014 *State of the State* address.

In 2012 ONDCP held an interagency meeting focused on heroin, as many agencies were concerned that prescription opioid users might migrate to heroin. The interagency prescription

[70] American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington VA, American Psychiatric Association. 2013. Page 541.
[71] IMS Health, National Prescription Audit, 2012
[72] Estimate presented by Thomas Frieden during oral presentation at Preventing Prescription Drug Overdose: New Challenges, New Opportunities. National RX Drug Abuse Summit, Operation Unite. Atlanta GA. April 8, 2014.
[73] Muhuri, P.K., Gfroerer, J.C., Davies, MC. SAMHSA CBHSQ Data Review. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013.

drug working group formed a research group to examine the nature of the transition from prescription opioids to heroin, and CDC and SAMHSA have increased their focus on this issue, developing additional analyses to help track and publicize the issue.[74,75]

In May 2015, the Administration held its inaugural meeting of the Congressionally-mandated interagency Heroin Task Force. This Task Force is co-chaired by ONDCP Deputy Director for State, Local and Tribal Affairs Mary Lou Leary and U.S. Attorney for the Western District of Pennsylvania David Hickton and includes Federal agency experts from law enforcement, medicine, public health and education. The Task Force report will highlight emerging evidence-based public health and public safety models for law enforcement engagement in activities that promote solutions to reduce demand or decrease spread of disease.

The *National Drug Control Strategy*'s efforts also include pursuing action against criminal organizations trafficking in opioid drugs, working with the international community to reduce cultivation of poppy, identifying labs creating dangerous synthetic opioids like fentanyl and acetyl-fentanyl and enhancing border efforts to decrease the flow of these drugs into the country.

Treatment, Overdose Prevention, and Other Public Health Efforts

The public health consequences of nonmedical opioid and heroin use are often similar if not identical. Most notably, in both cases, some proportion of individuals escalate use and eventually develop a chronic opioid use disorder requiring treatment. The low rate of cases referred to treatment by medical personnel in the face of such a dangerous epidemic suggests that providers may ignore or miss the problems of nonmedical prescription opioid use and heroin use among their patients. The extent of the opioid use problem requires that health care providers work in tandem with law enforcement to address the issue.

People who escalate use are vulnerable to begin injecting, and this behavior dramatically increases their risk of exposure to blood-borne infections, including human immunodeficiency virus (HIV) and hepatitis C. It is noteworthy that in the latest HIV outbreak in rural Indiana, it was intravenous use of the strong prescription opioid oxymorphone, not heroin, which accounted for most of the cases. Since the first patient in the outbreak was identified in January 2015, 174 people have tested positive for HIV. To combat the spread of HIV, Indiana instituted an emergency syringe services program, among other efforts to expand treatment for HIV and opioid use disorders. The Administration continues to support a consistent policy that would allow Federal funds to be used in locations where local authorities deem syringe services programs to be effective and appropriate. Studies show that comprehensive prevention and drug treatment programs, including syringe services program, have dramatically cut the number of new HIV infections among people who inject drugs.

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[74] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015

[75] Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25. PMID: 26158353

Nonmedical use of opioids like heroin can produce overdose including fatal overdose especially when used in conjunction with other sedatives including alcohol and anti-anxiety medicines. People who have stopped using for a period of time, such as those who were in treatment, have been medically withdrawn, or have been incarcerated, are especially at risk of overdose because their tolerance has worn off but they use amounts similar to those prior to cessation. When used chronically by pregnant women, both prescription opioids and heroin can cause withdrawal symptoms in newborns upon birth, and if these opioids are withdrawn during pregnancy, fetal harm may result.

For these reasons, it is important to identify and treat people with prescription opioid use disorder quickly, ensure they are engaged in the most effective forms of evidence-based treatment, and make lifesaving tools like the overdose reversal antidote naloxone widely available. Fortunately, the treatments for heroin and prescription opioid use disorder are the same. The standard of care is behavioral treatment plus stabilization on one of three FDA-approved medicines, often called medication-assisted treatment (MAT). MAT may be tapered in time to produce abstinence, but a health care provider must make the decision that is right for his or her patient regarding whether to cease a medication.

The Administration continues to focus on vulnerable populations affected by opioids, including pregnant women and their newborns. From 2000 to 2009 the number of infants displaying symptoms of drug withdrawal after birth, known as neonatal abstinence syndrome (NAS), increased approximately threefold nationwide.[76] Newborns with NAS have more complicated and longer initial hospitalizations than other newborns.[77] Newly published data shows the problem nearly doubled from 2009 to 2012.[78] Additionally, the study showed that 80 percent of the cost for caring for these infants was the responsibility of state Medicaid programs during this time.

The Administration is focusing on several key areas to reduce and prevent opioid overdoses from prescription opioids and heroin, including educating the public about overdose risks and interventions; increasing access to naloxone, an emergency opioid overdose reversal medication; and working with states to promote Good Samaritan laws and other measures that can help save lives. With the recent rise in opioid-involved overdose deaths across the country, it is increasingly important to prevent overdoses and make antidotes available.

It is important to note in some cases traffickers are combining heroin with the synthetic lab-produced opioid fentanyl or an analog, presumably as a way to increase user perception of

[76] Epstein, R.A., Bobo, W.V., Martin, P.R., Morrow, J.A., Wang, W., Chandrasekhar, R., & Cooper, W.O. (2013). Increasing pregnancy-related use of prescribed opioid analgesics. Annals of Epidemiology, 23(8): 498-503. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23889859.
[77] Patrick, S., Schumacher, R.E., Benneyworth, B.D., Krans, E.E., McAllister, J.M., & Davis, M.M. (2012). Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. Journal of the American Medical Association, 307(18): 1934-40. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22546608.
[78] Patrick, SW, Davis, MM, Lehman, CU, Cooper, WO. Incresing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009-2012. Journal of Perinatology (2015): 1-6 online publication, April 30, 2015; doi:10.1038/jp.2015.36

product strength and thus user experience.[79] Fentanyl can produce overdose rapidly in naïve users and in such cases naloxone may be insufficient remedy for fentanyl or its analogs.[80]

The Administration is providing tools to local communities to deal with the opioid drug epidemic. In August 2013, SAMHSA released the *Opioid Overdose Prevention Toolkit.*[81] This toolkit provides communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It contains information for first responders, treatment providers, and those recovering from opioid overdose. In July 2014, Attorney General Holder issued a Memorandum urging Federal law enforcement agencies to identify, train and equip personnel who may interact with victims of an opioid overdose,[82] and in October 2014, the Attorney General announced the launch of the Department of Justice's *Naloxone Toolkit* to support law enforcement agencies in establishing a naloxone program.[83] In August 2014, the Administration announced that DoD was making a new commitment to ensure that opiate overdose reversal kits and training are available to every first responder on military bases or other areas under DoD's control.[84] And earlier this month, the Indian Health Service announced its own toolkit for use with American Indian and Alaskan Natives a population who has disparate rates of past year non-medical prescription pain reliever use (6.9 percent vs. 4.2 percent in the rest of the population).[85]

The Administration continues to promote the use of naloxone by those likely to encounter overdose victims and for them to be in the position to reverse the overdose, especially first responders and caregivers. The Administration's FY 2016 Budget requests $12 million in grants to be issued by SAMHSA to states to purchase naloxone, equip first responders in high-risk communities, and provide education and the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts. Profiled in the 2013 *National Drug Control Strategy*, the Quincy Massachusetts Police Department has partnered with the State health department to train and equip police officers to resuscitate overdose victims using naloxone. The Department reports that since October 2010, officers in Quincy have administered naloxone in more than 382 overdose events, resulting in 360 successful overdose reversals.[86] In the past year, we have witnessed an exponential expansion in the number of police departments that are training and equipping their police officers with naloxone. They now number in the hundreds.

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[79] Notes from the field: increase in fentanyl-related overdose deaths - Rhode Island, November 2013-March 2014.
Mercado-Crespo MC, Sumner SA, Spelke MB, Sugerman DE, Stanley C; EIS officer, CDC.
MMWR Morb Mortal Wkly Rep. 2014 Jun 20;63(24):531. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6324a3.htm
[80] Zuckerman M, Weisberg SN, Boyer EW. Pitfalls of intranasal naloxone.Prehosp Emerg Care. 2014 Oct-Dec;18(4):550-4. doi: 10.3109/10903127.2014.896961. Epub 2014 May 15. Available at linked to on.
[81] Substance Abuse and Mental Health Services Administration. Opioid Overdose Prevention Toolkit. Department of Health and Human Services. [August 2013]. Available: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742
[82] Department of Justice, Office of Public Affairs. "Attorney General Holder Announces Plans for Federal Law Enforcement Personnel to Begin Carrying Naloxone." [July 31, 2014]. Available at http://www.justice.gov/opa/pr/attorney-general-holder-announces-plans-federal-law-enforcement-personnel-begin-carrying linked to 10-18-2014
[83] Department of Justice, Office of Public Affairs. "Remarks by Attorney General Holder at the International Association of Chiefs of Police Annual Conference." [October 27, 2014]. Available at: http://www.justice.gov/opa/speech/remarks-attorney-general-holder-international-association-chiefs-police-annual-conference
[84] http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf
[85] SAMHSA. National Survey on Drug Use and Health. The CBHSQ Report, June 2015.Nonmedial use of prescription pain relievers varies by race. http://www.samhsa.gov/data/sites/default/files/report_1972/Spotlight-1972.html linked to on 7-19-2015.
[86] Quincy (Massachusetts) Police Department Reporting. Email received 3/15/15.

Extraordinary collaboration is taking place in rural and suburban communities such as Lake County, Illinois. As part of the Lake County Heroin/Opioid Prevention Taskforce, the Lake County State's Attorney has partnered with various county agencies, including the Lake County Health Department; drug courts; police and fire departments; health, advocacy and prevention organizations; and local pharmacies to develop and implement an opioid overdose prevention plan.[87] Since July 2014, the Lake County Health Department has trained more than 34 police departments, 27 of which are carrying naloxone. As of February 2015, the Lake County Health Department had trained 828 police officers and 200 sheriff's deputies to carry and administer naloxone, and more departments have requested this training.[88]

Prior to 2012, just six states had any laws which expanded access to naloxone or limited criminal liability. Today, 35 states[89] and the District of Columbia have passed laws that offer criminal and/or civil liability protections to lay persons or first responders who administer naloxone. Twenty-four states[90] have passed laws that offer criminal and/or civil liability protections for prescribing or distributing naloxone. Thirty-three states[91] have passed laws allowing naloxone distribution to third-parties or first responders via direct prescription or standing order. ONDCP is collaborating with state health and law enforcement officials to promote best practices and connect officials interested in starting their own naloxone programs. The odds of surviving an overdose, much like the odds of surviving a heart attack, depend on how quickly the victim receives treatment. Twenty-five states[92] and the District of Columbia have passed laws which offer protections from charge or prosecution for possession of a controlled substance and/or paraphernalia if the person seeks emergency assistance for someone that is experiencing an opioid induced overdose. As these laws are implemented, the Administration will carefully monitor their effect on public health and public safety.

The Affordable Care Act and Federal parity laws are extending access to mental health and substance use disorder benefits for an estimated 62 million Americans.[93] This represents the largest expansion of treatment access in a generation and could help guide millions into successful recovery. The President's FY 2016 budget request includes $11 billion for treatment, a nearly seven percent increase over the FY 2015 funding level.

It is essential to identify and engage people who use prescription opioids non-medically early because the risks of being infected with HIV or hepatitis C increases dramatically once someone transitions to injection drug use. It is much less expensive to treat a person for just a substance use disorder early using evidence-based treatment, rather than to treat a person with a substance use disorder and provide lifetime treatment for HIV or a cure for hepatitis C.

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[87] Office of the State's Attorney, Lake County, Illinois, Michael G. Nerheim. "Call to Action Lake County Opioid Prevention Initiative." [May 29, 2013]. Available at: http://lcsao.org/news/press-releases

[88] Lake County Health Department Reporting. Email 2/19/15.

[89] CA, CO, ID, OR, UT, WA, AZ, NM, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, RI, VT, IL, IN, MI, MN, MO, OH, SD, and WI.

[90] CA, CO, ID, UT, AZ, NM, GA, MS, NC, TN, VA, WV, CT, MA, NJ, NY, PA, VT, IN, MI, MN, OH, SD, and WI.

[91] CA, CO, ID, OR, UT, WA, AZ, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, VT, IL, IN, MI, MN, MO, OH, SD, and WI.

[92] AK, CA, CO, UT, WA, NM, FL, GA, KY, LA, NC, WV, CT, DE, MA, MD, NJ, NY, PA, RI, VT, IL, IN, MN, and WI.

[93] Berino, K., Rosa, P., Skopec, L. & Glied, S. (2013). Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. *Research Brief.* Assistant Secretary for Planning and Evaluation (ASPE). Washington, DC (Citation: Abstract of the Brief found at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

Medication-assisted treatment should be the recognized standard of care for opioid use disorders. Research shows that even heroin users can sustain recovery if treated with evidence-based methods. Studies have shown that individuals with opioid use disorders have better outcomes with maintenance MAT.[94] Yet for too many people, it is out of reach. For instance, only 26.2 percent (3,713) of treatment facilities provided treatment with methadone and/or buprenorphine.[95] Treatment programs are too often unable to provide this standard of care, and there is a significant need for medical professionals who can provide MAT in an integrated health care setting.

Medicines for opioid use disorder containing buprenorphine are important advancements that have only been available since Congress passed the Drug Addiction Treatment Act of 2000 (DATA 2000). They expand the reach of treatment beyond the limited number of heavily regulated Opioid Treatment Programs that generally dispense methadone. Also because physicians who have taken the training to administer the medicines are allowed to treat patients in an office-based setting, it allows patient care to be integrated with mainstream medicine. Injectable naltrexone offers similar advantages but only to patients who have been abstinent from opioids for 7-10 days. Special training required by DATA 2000 for prescribing buprenorphine is not required for injectable naltrexone.

We need to increase the number of physicians who can prescribe buprenorphine, when appropriate and the numbers of providers offering injectable naltrexone. Of the more than 877,000 physicians who can write controlled substance prescriptions, only about 29,194 have received a waiver to prescribe office-based buprenorphine. Of those, 9,011 had completed the requirements to serve up to 100 patients. The remainder can serve up to 30. Although they are augmented by an additional 1,377 narcotic treatment programs, far too few providers elect to use any form of medication-assisted treatment for their patients.[96] Injectable naltrexone was only approved for use with opioid use disorders in 2012, and little is known about its adoption outside specialty substance use treatment programs but use in primary care and other settings are possible. To date only about 3 percent of U.S. treatment programs offer this medicine for opioid use disorder.[97] Education on the etiology of opioid abuse and clinician interventions is critical to increasing access to treatments that will stem the tide of opioid misuse and overdose.

And there are some signs that these national efforts are working with respect to the prescription opioid problem. The number of Americans 12 and older initiating the nonmedical use of prescription opioids in the past year has decreased significantly since 2009, from 2.2 million in that year to 1.5 million in 2013.[98] Additionally, according to the latest Monitoring the

[94] Weiss RD, Potter JS, Griffin ML, McHugh RK, Haller D, Jacobs P, Gardin J 2nd, Fischer D, Rosen KD. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial Published in final edited form as: Arch Gen Psychiatry. 2011 December; 68(12): 1238 1246.

[95] SAMHSA. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012 -- Data on Substance Abuse Treatment Facilities* (December 2013).

[96] Personal communication (email) from Robert Hill (DEA).

[97] Aletraris L, Bond Edmond M1, Roman PM1., Adoption of injectable naltrexone in U.S. substance use disorder treatment programs. J Stud Alcohol Drugs. 2015 Jan;76(1):143-51.

[98] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.36A

Future survey, the rate of past year use among high school seniors of OxyContin or Vicodin in 2014 is its lowest since 2002.[99]

However, while all of these trends are promising, the national data cited earlier concerning increases in emergency department visits, treatment admissions, and overdoses involving opioids bring the task ahead of us into stark focus. Continuing challenges with prescription opioids, and concerns about a reemergence of heroin use, particularly among young adults, underscore the need for leadership at all levels of government.

Conclusion

We continue to work with our Federal, state, local, and tribal partners to continue to reduce and prevent the health and safety consequences of nonmedical prescription opioid and heroin use. Together with all of you, we are committed partners, working to reduce the prevalence of substance use disorders through prevention, increasing access to treatment, and helping individuals recover from the disease of addiction. Thank you for the opportunity to testify here today, and for your ongoing commitment to this issue. I look forward to continuing to work with you on this pressing public health matter.

[99] The Monitoring the Future study. *Narcotics other than Heroin: Trends in Annual Use and Availability – Grades 8, 10, and 12*. University of Michigan. [December 2014]. Available: http://www.monitoringthefuture.org/data/14data/14drfig11.pdf

Mr. SENSENBRENNER. Thank you, Mr. Botticelli.
Mr. Riley?

TESTIMONY OF JOHN (JACK) RILEY, ACTING DEPUTY ADMINISTRATOR, DRUG ENFORCEMENT ASSOCIATION

Mr. RILEY. Chairman Sensenbrenner, Chairman Goodlatte, Congressman Chu, and distinguished Members of the Subcommittee, thanks for the opportunity to discuss heroin, its use and availability, and DEA's response.

DEA's single mission is enforcing the Controlled Substances Act, and heroin has always been a major focus of our efforts over the years. Sadly today, 120 Americans will die as a result of drug overdose. Heroin and prescription painkillers cause over half of those fatalities. Accordingly, DEA views the opioid addiction epidemic as really the number-one problem facing the country.

I have been with DEA almost 30 years, and I have to tell you I have never seen it this bad. Heroin destroys individuals, families, and communities. The vast majority of the heroin abused in the United States is manufactured outside of our country and smuggled across our Southwest border. In recent years, we have seen an increase in poppy cultivation and heroin production in Mexico. As a result, Mexican heroin is more prevalent on our streets today, accounting for approximately half of the domestic supply.

The role of Mexican organized crime is unprecedented, which is why DEA's relationship with our Mexican counterparts and our presence along the border is so vital. DEA is addressing this evolving threat by targeting the highest-level traffickers and the vicious organizations they run. I have personally spent the bulk of my career chasing the man I consider to be the most dangerous heroin dealer in the world, Chapo Guzman. He and his Sinaloa Cartel dominate the U.S. heroin market.

DEA focuses its resources on disrupting and dismantling these organizations, both at home and abroad. That means targeting the intersections between Mexican organized crime and violent urban gangs distributing the heroin on their behalf. The relationship between these two criminal entities can only be described as dangerous and toxic.

Heroin can be found in virtually every corner of our country, in places I have never seen it before, large and small, urban and rural. Today, heroin is far different than it was just 5 years ago. It is cheaper, higher in purity, and can be smoked and snorted, much like powder cocaine. Unfortunately, there is no typical heroin addict. The problem transcends all demographic and social/economic lines.

Knowing this drug is a source of so much violence in our communities is really what keeps me up at night. I know from experience the more we do to reduce drug crime, the more we will do to reduce all violent crime. While Special Agent in Charge of the Chicago Field Division, we developed a model of cooperation and collaboration that I believe is making a difference there and across the country. The Chicago Heroin Strike Force began with a shared belief among Federal, state, and local law enforcement, political leaders, community leaders, and prosecutors that together we could effectively target violent heroin organizations trafficking in heroin.

As a result of our efforts, seizures dramatically increased, as did the number of arrests and convictions of drug traffickers, primarily those connected to violence. We also dismantled criminal organizations responsible for the distribution of hundreds, even thousands of kilos of heroin and other drugs. Consequently, we made our communities safer.

This new and innovative strategy also allows us to work to the street level to prevent violent crime, while at the same time to pursue the investigation into the highest level of cartel leadership, wherever that takes us. We are actively looking to make this a DEA model across the country.

Just as we cannot separate violence from drugs, we cannot separate controlled prescription drug abuse from heroin. As a result, DEA has established highly effective tactical diversion squads across the country, 66 in total, as part of the commitment to target the critical nexus between the diversion of prescription drugs and heroin. Indeed, we are taking steps to remove unwanted, unneeded and expired prescription drugs from medicine cabinets. In fact, on September 26, 2015, DEA will host its 10th national take-back initiative.

I know firsthand these threats are an urgent challenge and a danger to the communities and the lives of our citizens, but law enforcement is not the sole answer. Prevention, treatment, education and awareness are critical to our success. Everybody plays a role in this problem, from parents, community leaders, educators, faith-based organizations, coaches and athletics, and the medical community. This is a marathon, not a sprint, but together we will produce the results you seek and the American people demand. Thank you.

[The prepared statement of Mr. Riley follows:]

Department of Justice

STATEMENT OF

JACK RILEY
ACTING DEPUTY ADMINISTRATOR
DRUG ENFORCEMENT ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, HOMELAND SECURITY, AND INVESTIGATIONS
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

FOR A HEARING CONCERNING

THE ESCALATION IN THE ABUSE OF HEROIN AND OTHER DANGEROUS DRUGS

PRESENTED

JULY 28, 2015

Statement of Jack Riley
Acting Deputy Administrator
Drug Enforcement Administration
Before the
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations
Committee on the Judiciary
U.S. House of Representatives
July 28, 2015

INTRODUCTION

Chairman Sensenbrenner, Ranking Member Jackson Lee, and distinguished Members of the Subcommittee, on behalf of the approximately 9,000 employees of the Drug Enforcement Administration (DEA), thank you for the opportunity to discuss heroin use, its availability here in the United States and the DEA's response to the threat.

Drug overdoses are the leading cause of injury-related death here in the United States, eclipsing deaths from motor vehicle crashes.[1] There were over 43,000 deaths in 2013, or approximately 120 per day, over half of which involved either a prescription painkiller or heroin. These are our family members, friends, neighbors, and colleagues.

Overdose deaths involving heroin are increasing at an alarming rate having almost tripled since 2010. Today's heroin at the retail level costs less and is more potent than the heroin that DEA encountered a decade ago. It comes predominantly across the Southwest Border (SWB) and is produced with greater sophistication from powerful transnational criminal organizations (TCOs) like the Sinaloa Cartel. These Mexican-based TCO's are extremely dangerous and violent and continue to be the principal suppliers of heroin to the United States.

DEA is addressing the threat both internationally and domestically. DEA prioritizes its resources by identifying and targeting the world's biggest and most powerful drug traffickers, designated as Consolidated Priority Organization Targets (CPOTs), as well as other Priority Target Organizations (PTOs). We partner internationally with our foreign host-nation counterparts through our Sensitive Investigative Unit (SIU) and Bilateral Investigations Units (BIU) programs.

Domestically, our enforcement teams are targeting heroin distribution cells which have become an increasing threat to the safety and security of our communities due to their increasing alliances with Mexican TCOs. By partnering with Federal, state, and local law enforcement, through programs such as the High Intensity Drug Trafficking Areas (HIDTA) program, the Organized Crime Drug Enforcement Task Force (OCDETF) regions, etc., we are identifying and disrupting these drug traffickers. During FY 2014, DEA initiated 2,049 heroin cases, an increase of 141% over the number opened in 2007. In addition, our tactical diversion squads (TDS) are identifying those individuals in the prescription drug supply chain who are diverting controlled

[1] Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS) [online], (2014), *available at*: http://www.cdc.gov/injury/wisqars/fatal.html.

prescription drugs (CPDs). Once identified, the TDSs use administrative, civil, and criminal tools to bring these individuals to justice.

Finally, on September 9, 2014, DEA issued a final rule titled "Disposal of controlled substances" to help focus national attention on the issue of nonmedical use of prescription drugs and related substance use disorders (SUDs), promote awareness that one source of these drugs is often the home medicine cabinet, and provide a safe and legal method for the public to dispose of unwanted CPDs through DEA's National Drug Take Back Initiative (NTBI). Since 2010, DEA has sponsored nine Take Back events and recently announced its intent to reinstitute NTBI in the future.

CURRENT ASSESSMENT OF THE THREAT

Increased demand for, and use of heroin is being driven by both increasing availability of heroin in the U.S. market and by individuals with opioid use disorders using heroin. Individuals with opioid use disorders who begin using heroin do so because of price differences (i.e., heroin is less expensive), but also because of increasing heroin availability relative to opiate based CPDs as well as the reformulation of OxyContin®, a highly sought opioid.[2]

Heroin overdose deaths are increasing in many cities and counties across the United States, but particularly in the Mid-Atlantic, New England, New York/New Jersey Regions, certain parts of Appalachia, and areas of the Midwest. Possible reasons for these increases in overdose deaths include an overall increase in heroin use; high purity batches hitting certain markets causing unintentional overdose; an increase in new heroin initiates (many of whom may be inexperienced); nonmedical use of prescription opioids initiating use of heroin; and the addition of extremely potent adulterants such as fentanyl in certain markets.

According to the DEA's 2015 National Drug Threat Survey (NDTS), 38 percent of law enforcement respondents reported that heroin was the greatest drug threat in their area; more than any other drug. Since 2007, the percentage of NDTS respondents reporting heroin as the greatest threat has steadily grown, from 8 percent in 2007 to 38 percent in 2014. The OCDETF regions with the largest number of respondents ranking heroin as the greatest drug threat were the Mid-Atlantic, Great Lakes, New England, and New York/New Jersey.

Data from the National Seizure System (NSS), demonstrates that domestic heroin seizures have increased 81 percent over five years, from 2,763 kilograms in 2010 to 5,014 kilograms in 2014. Traffickers are also transporting heroin in larger amounts. The average size of a heroin seizure in 2010 was 0.86 kilograms; in 2014, the average heroin seizure was 1.74 kilograms. According to the DEA's National Forensic Laboratory Information System, which collects drug identification results from drug cases submitted to and analyzed by Federal, state, and local forensic laboratories, there has been a 37 percent increase in heroin samples analyzed from 2009 to 2013 (from 108,778 to 149,479 samples).

[2] Cicero, Theodore J., PhD; Matthew S. Ellis, MPE; Hilary L. Surratt. PhD; Steven P. Kurtz, PhD, The Changing Face of Heroin Use in the United States; A Retrospective Analysis of the Past 50 Years, July 2014.

AVAILABILITY OF HEROIN FOR THE U.S. MARKET

There are four major heroin-producing areas in the world, but heroin bound for the U.S. market originates predominantly from Mexico, and to a lesser extent, Colombia. The heroin market in the United States has been historically divided along the Mississippi River, with western markets using Mexican black tar and brown powder heroin, and eastern markets using white powder which, over the last two decades has been sourced primarily from Colombia. The largest, most lucrative heroin markets in the United States are the white powder markets in major eastern cities: New York City and the surrounding metropolitan areas, Philadelphia, Chicago, Boston and its surrounding cities, Washington, D.C., and Baltimore. With the growing number of individuals with an opioid use disorder in the United States, Mexican TCOs have seized upon a business opportunity to increase their profits. Mexican TCOs are now competing for the East Coast and Mid-Atlantic markets by introducing Mexican brown/black tar heroin as well as by developing new techniques to produce highly refined white powder heroin.

DEA has also seen a 50 percent increase in poppy cultivation in Mexico primarily in the State of Guerrero and the Mexican "Golden Triangle" which includes the states of Chihuahua, Sinaloa, and Durango. The increased cultivation results in a corresponding increase in heroin production and trafficking from Mexico to the United States, and impacts both of our nations, by supporting the escalation of heroin use in the United States, as well as the instability and violence growing throughout areas in Mexico.

TRAFFICKING ALONG THE SOUTHWEST BORDER (SWB)

The majority of Mexican and Colombian heroin bound for the United States is smuggled into the United States via the SWB, and heroin seizures at the border have more than doubled, from 846 kilograms in 2009 to 2,188 kilograms in 2014.[3] During this time, the average seizure also increased from 2.9 kilograms to 3.8 kilograms. The distribution cells and the Mexican and South American traffickers who supply them are the main sources of heroin in the United States today. The threat of these organizations is magnified by the high level of violence associated with their attempts to control and expand drug distribution operations.

USE AND DEMAND

According to the 2013 National Survey on Drug Use and Health (NSDUH), 6.5 million people over the age of 12 used psychotherapeutic drugs for non-medical reasons during the past month – of these, 4.5 million reported non-medical use of prescription opioids. This represents 26 percent of illicit drug users and is second only to marijuana in terms of popularity. There are more current users of psychotherapeutic drugs for non-medical reasons than current users of cocaine, heroin, and hallucinogens combined.

In 2013, 169,000 persons aged 12 or older used heroin for the first time within the previous 12 months. Among recent initiates aged 12 to 49, the average age for first-time heroin

[3] Drug Enforcement Administration, Unclassified Summary, 2015 National Drug Threat Assessment, Pg. 10, *available at*: http://www.dea.gov/resource-center/dir-ndta-unclass.pdf.

use was 24.5 years, which was similar to the 2012 estimate (23.0 years).[4] Notably, a special analysis of NSDUH data indicates that 86 percent of heroin initiates between the ages of 12 and 49 in 2009-2011 had previously used pain relievers non-medically.[5] While the number of CPD abusers initiating heroin use is a small percentage of the total number of CPD abusers from 2002 to 2011, it represented a large percentage of new heroin initiates.

Black-market sales for CPDs are typically five to ten times their retail value. DEA intelligence reveals the "street" cost of prescription opioids steadily increases with the relative strength of the drug. For example, generally, hydrocodone combination products (a Schedule II prescription drug and also the most prescribed CPD in the country)[6] can be purchased for $5 to $7 per tablet. Slightly stronger drugs like oxycodone combined with acetaminophen (e.g., Percocet) can be purchased for $7 to $10 per tablet. Even stronger prescription drugs are sold for as much as $1 per milligram (mg). For example, 30 mg oxycodone (immediate release) and 30 mg oxymorphone (extended release) cost $30 to $40 per tablet. These increasing costs make it difficult to purchase in order to support the addiction, particularly when many first obtain these drugs for free from the family medicine cabinet or friends. Data from the National Survey on Drug Use and Health show that the more chronic an opioid use disorder becomes, the more likely the individual is to buy opioid drugs from a dealer.[7] Not surprisingly, some users of prescription opioids turn to heroin, a much cheaper opioid, generally $10 per bag, which provides a similar "high" and keeps individuals with opioid use disorders from experiencing painful withdrawal symptoms. This cycle has been repeatedly observed by law enforcement agencies. For some time now, law enforcement agencies across the country have been specifically reporting an increase in heroin use by those who began using prescription opioids non-medically.[8]

Healthcare providers as well as those abusing CPDs are confirming this increase. According to some reporting by treatment providers, many individuals with serious opioid use disorders will use whichever drug is cheaper and/or available to them at the time. Individuals with opioid use disorders are known to switch back and forth between prescription opioids and heroin, depending on price and availability. Individuals with opioid use disorders who have recently switched to heroin are at high risk for accidental overdose. Unlike with prescription drugs, heroin purity and dosage amounts vary, and heroin is often cut with other substances (e.g.

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[4] Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[5] Muhuri, P.K., Gfroerer J., & Davies, C. (2013). Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. CBHSQ Data Review. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm.

[6] On October 6, 2014, DEA published a final rule in the *Federal Register* to move hydrocodone combination products from Schedule III to Schedule II, as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services.

[7] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013. Unpublished special tabulations (March 2015).

[8] U.S. Department of Justice, Drug Enforcement Administration, 2015 National Heroin Threat Assessment Summary, DEA Intelligence Report, April, 2015, *available at*: http://www.dea.gov/divisions/hq/2015/hq052215_National_Heroin_Threat_Assessment_Summary.pdf.

fentanyl), all of which could cause individuals with lower tolerance to higher potency opioids to accidentally overdose.[9]

Some CPD users become dependent on opioid medications originally prescribed for a legitimate medical purpose.[10] A Substance Abuse and Mental Health Services Administration (SAMHSA) study found that four out of five recent new heroin users had previously used prescription pain relievers non-medically, although a very small proportion (3.6%) of those initiated heroin use in the following five-year period.[11] The reasons an individual may shift from one opiate to another vary, but today's heroin is higher in purity, less expensive, and often easier to obtain than illegal CPDs. Higher purity allows heroin to be smoked or snorted, thereby circumventing a barrier to entry (needle use) and avoiding the stigma associated with injection. However many who smoke or snort are vulnerable to eventually injecting. Heroin users today tend to be younger, more affluent, and more ethnically and geographically diverse than ever before.[12]

FENTANYL AND FENTANYL ANALOGUES

DEA has become increasingly alarmed over the addition of fentanyl into heroin sold on the streets as well as the use of fentanyl analogues such as acetyl fentanyl. One of the most potent Schedule II narcotics which is 25 to 40 times more potent than heroin,[13] fentanyl presents a serious increased risk of overdose death for a heroin user. In addition, this drug can be absorbed by the skin or inhaled, which makes it particularly dangerous for law enforcement officials who encounter the substance during the course of an enforcement operation. On March 18, 2015, DEA issued a nationwide alert to all U.S. law enforcement officials about the dangers of fentanyl and fentanyl analogues and related compounds. In addition, due to a recent spike in overdose deaths related to the use of acetyl fentanyl; on July 17, 2015, DEA used its emergency scheduling authority to place acetyl fentanyl in Schedule I of the Controlled Substances Act (CSA).

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[9] Stephen E. Lankenau, Michelle Teti, Karol Silva, Jennifer Jackson Bloom, Alex Harocopos, and Meghan Treese, Initiation into Prescription Opioid Misuse Among Young Injection Drug Users, Int J Drug Policy, Author manuscript; available in PMC 2013 Jan 1, Published in final edited form as: Int J Drug Policy, 2012 Jan; 23(1): 37-44. Published online 2011 Jun 20. doi: 1016/j.drugpo.2011.05.014. and; Mars SG, Bourgois P, Karandinos G, Montero F, Ciccarone D., "Every 'Never' I Ever Said Came True": Transitions From Opioid Pills to Heroin Injecting, Int J Drug Policy, 2014 Mar;25(2):257-66. doi: 10.1016/j.drugpo.2013.10.004. Epub 2013 Oct 19.

[10] Pain, 2015 Apr; 156(4):569-76, doi: 10.1097/01.j.pain.0000460357.01998.f1, Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. Vowles KE1, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN.

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

[12] Cicero, T., Ellis, M., Surratt,H, Kurtz, S. The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years, July, 2014.

[13] Centers for Disease Control, Emergency Response Safety and Health Database, FENTANYL: Incapacitating Agent, http://www.cdc.gov/niosh/ershdb/emergencyresponsecard_29750022.html, accessed March 19, 2015; U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drug & Chemical Evaluation Section, Fentanyl, March 2015.

DEA's RESPONSE TO THE CURRENT HEROIN AND OPIOID THREAT

Anti-Heroin Task Force Program

As directed by Congress, the Department of Justice has joined with the Office of National Drug Control Policy (ONDCP) to convene an interagency task force to confront the growing use, abuse, and trafficking of heroin in America. DEA and more than 28 Federal agencies and their components are actively participating in this initiative. The task force expects to have a strategic plan for the President and Congress by the end of 2015.

International Enforcement: Sensitive Investigative Units

Funds requested for International Drug Enforcement Priorities will be used to support and expand a key element of DEA's international efforts: the Sensitive Investigative Unit (SIU) program. DEA's SIU program, nine of which are in the western hemisphere, helps build effective and vetted host nation units capable of conducting complex investigations targeting major TCOs. DEA currently mentors and supports 13 SIUs, which are staffed by over 900 foreign counterparts. The success of this program has unquestionably enhanced DEA's ability to fight drug trafficking on a global scale.

International Enforcement: Bilateral Investigations Units

Bilateral Investigations Units (BIUs) are one of DEA's most important tools for targeting, disrupting, and dismantling significant TCOs. The BIUs have used extraterritorial authorities to infiltrate, indict, arrest, and convict previously "untouchable" TCO leaders involved in drug trafficking.

Domestic Enforcement: Tactical Diversion Squads

DEA Tactical Diversion Squads (TDSs) investigate suspected violations of the CSA and other Federal and state statutes pertaining to the diversion of controlled substance pharmaceuticals and listed chemicals. These unique groups combine the skill sets of Special Agents, Diversion Investigators, and a variety of state and local law enforcement agencies. They are dedicated solely to investigating, disrupting, and dismantling those individuals or organizations involved in diversion schemes (e.g., "doctor shoppers," prescription forgery rings, and practitioners and pharmacists who knowingly divert CPDs). Since September 30, 2014, DEA has deployed 66 Tactical Diversion Squads (TDS) in 41 states, the District of Columbia, and Puerto Rico. Case initiations increased from 691 in 2005 to 1,727 in 2014, while arrests increased from 105 in 2005 to 2,418 in 2014.

Domestic Enforcement: Regulatory Investigations

When the DEA was established in 1973, DEA regulated 480,000 registrants. Today, DEA regulates more than 1.58 million registrants. The expansion of the TDS groups has allowed Diversion Groups to concentrate on the regulatory aspects of enforcing the CSA. DEA has steadily increased the frequency of compliance inspections of specific registrant categories

such as manufacturers (including bulk manufacturers), distributors, pharmacies, importers, exporters, and narcotic treatment programs. This renewed focus on oversight has enabled DEA to take a more proactive approach to educating registrants of their corresponding responsibilities under the CSA and its implementing regulations.

National Drug Take Back Initiative (NTBI):

On September 25, 2010, DEA began coordinating NTBIs to help focus national attention on the issue of nonmedical prescription drug use; promote awareness that one source of these drugs is often the home medicine cabinet; and provide a safe and legal method for the public to dispose of unwanted CPDs. These "take back" events were sponsored by the DEA while it prepared regulations that established permanent disposal methods, which was published on October 6, 2014. Since its first National Take Back Day in September of 2010, DEA has collected more than 4.1 million pounds (over 2,100 tons) of prescription drugs throughout all 50 states, the District of Columbia, and several U.S. territories.

CONCLUSION

The supply of heroin entering the United States feeds the increasing user demand for opioids which has been spurred, in part by the rise of nonmedical prescription opioid use and untreated substance use disorders. It is likely that this demand will continue to be met primarily by Mexican-based TCOs who are pushing to expand their profits. DEA will continue to address this threat by attacking the crime and violence perpetrated by the Mexican-based TCOs which have brought tremendous harm to our communities. Additionally, DEA's Office of Diversion Control will use all criminal and regulatory tools possible to identify, target, disrupt, and dismantle individuals and organizations responsible for the illicit manufacture and distribution of pharmaceutical controlled substances in violation of the CSA. The Anti-Heroin Task Force will develop a comprehensive strategy that will combine education; law enforcement; treatment and recovery; and a coordinated community response.

Mr. SENSENBRENNER. Thank you, Mr. Riley.
Ms. Parr?

TESTIMONY OF NANCY G. PARR, COMMONWEALTH'S ATTORNEY, CITY OF CHESAPEAKE, VA

Ms. PARR. Mr. Chairman, Members of the Committee, I appreciate the opportunity to be here today and to speak to you.

For the past 12 to 18 months, I have learned a great deal about drug overdose deaths, prescription and illegal drugs, and part of that is because I serve on the State Child Fatality Review Team and we are reviewing poisonings of our youth, and that includes narcotics, and also with a number of adult overdose deaths in my city.

For the past 30 years as a prosecutor, I have learned a lot about distributing drugs, and I have learned about simply possessing drugs. There is a difference. There is a big difference.

For the past 30 years as a prosecutor, I have learned a lot about property crimes, public safety, and what victims of crimes and law-abiding citizens expect and deserve from their local law enforcement and from their state law enforcement.

I appreciate the hold that drugs have on some people. We may all have family or friends, or friends who have children who are addicted to either prescription drugs or heroin or cocaine. I appreciate the pain that they experience for what they go through. And I appreciate that very few people who are addicted to drugs or to anything can break the cycle of addiction by themselves and alone. But I also know that many of them die alone.

And I also know that we all want to save lives.

Users, whether they are incarcerated or not, should have access to good, affordable treatment. Dealers should be incarcerated. Store owners should not have their merchandise stolen by addicts who are in there stealing to support their habit. Law-abiding citizens should be able to live peacefully in their homes and in their neighborhoods without dealers servicing their clients on the street corners, in the parking lots, or in the house next door. And they should also not be subject to being in the middle of the crossfire when the wars break out amongst the gangs and the drug dealers over who is going to run what street corner or what street. We have innocent people being shot and killed throughout this country because of drug dealers engaging in gunfire.

The generations before us did not find a way to stop drug use or abuse, and I don't think anybody realistically thinks that this generation is going to do so either. But we can all work together to diminish the devastation of the impact of the drugs.

Now, all of the disciplines involved in this have to be at the table because I am a prosecutor, I am not a therapist. I don't know what therapies work. I can listen and I can learn. So we all have to be at the table.

The comprehensive Addiction and Recovery Act I support very strongly, and I have permission from the National District Attorneys Association to state that the Association supports it also because of the three important things: the connection between prescription drugs and heroin use; alternative evidence-based programs for incarcerated veterans; substance abuse and mental

health. They often go hand in hand together. And grants for money for naloxone for local law enforcement.

There are five components that I see, and each one serves a very valid purpose: prevention, intervention, treatment, diversion, and incarceration.

Thank you.

[The prepared statement of Ms. Parr follows:]

COMMONWEALTH OF VIRGINIA

OFFICE OF THE COMMONWEALTH'S ATTORNEY
CITY OF CHESAPEAKE

Nancy G. Parr
Commonwealth's Attorney

TESTIMONY OF

NANCY G. PARR
COMMONWEALTH'S ATTORNEY
CITY OF CHESAPEAKE, VIRGINIA

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, HOMELAND SECURITY,
AND INVESTIGATIONS
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OR REPRESENTATIVES

FOR A HEARING ENTITLED

AMERICA'S GROWING HEROIN EPIDEMIC

PRESENTED ON

JULY 28, 2015

307 Albemarle Drive, Suite 200A • Chesapeake, Virginia 23322-5577 • Telephone (757) 382-3200 • Fax (757) 382-3227

Mr. Chairman, and distinguished members of the Subcommittee on Crime, Terrorism, Homeland Security and Investigations:

Thank you for the opportunity to appear today to discuss the important topic of the abuse of heroin and other dangerous drugs. It is an honor and a privilege to be invited to offer input on an issue that is impacting my city and my state.

I. Introduction

In the past twelve months, I have read, studied, discussed, debated, learned, argued about and compromised on what are the better ways to address the growing heroin use and prescription drug abuse in the Commonwealth of Virginia. I use the word "better" as opposed to "best" because the past twelve months have not convinced me that there is one, across the board, solution, prevention or intervention.

Serving on the Governor's Task Force on Prescription Drug and Heroin Abuse, on the State Child Fatality Review Team, and as President of the Virginia Association of Commonwealth's Attorneys, I have listened to and spoken about concerns and ideas to address this problem. I appreciate this opportunity to share some of this information.

II. Increase

In Chesapeake, Virginia, fatal drug overdose increased 72% from 2013 to 2014 and non-fatal overdoses increased 64% for the same period. The statistics for the first six months of 2015 appear to be stable for the fatal overdoses and higher for the non-fatal overdoses.

In reviewing autopsies for 2014 and 2015 deaths involving drug overdoses, I found that there have been twenty such deaths since January 2014. Eleven were male and nine were female. Ages ranged from 18 to 59 with the largest number in the 30's. Eleven died in their own homes apparently alone at the time. Ten had prior contact with the criminal justice system and

two of the ten were on bond. The prior criminal charges include DUI, domestic assault, robbery, burglary, malicious wounding, PWID, and simple possession. Not all twenty included heroin in the cause of death. However, ten did involve heroin. For the remaining ten, cause of death for five was fentanyl (had been bought as heroin), for one was methadone (no valid prescription), for one was prescription drugs, and for three was cocaine (including one with fentanyl).

According to my local law enforcement, the price of heroin has decreased by 50% or more because of the increase in supply and availability. Today's heroin is stronger and often deluded (cut) with other drugs (often Fentanyl aka "Drop Dead"). In Chesapeake, in a relatively short period of time, crack cocaine is becoming less common and heroin is becoming more common.

In Virginia, the statistics are overwhelming. According to the Office of the Chief Medical Examiner, each year approximately 70% of all drug deaths are due to one or more opiates (heroin and/or prescription drugs). In 2013, drug deaths became the number one (n=912) method of death in Virginia. Almost 82% of these deaths were determined to be accidental and only .1% homicide.[1] Kathrin Hobron, MPH, Statewide Forensic Epidemiologist, has advised me that this number could surpass 1,000 for 2014.

Also, in 2013, over 42% of the drug deaths in Virginia were caused by prescription drugs. Fentanyl, hydrocodone, methadone, and oxycodone (FHMO) were found to be partly or wholly responsible for 386 drug only deaths in 2013. Oxycodone was the most commonly used FHMO resulting in death.[2]

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[1] Office of the Chief Medical Examiner's Annual Report, 2013, Commonwealth of Virginia, Virginia Department of Health, created by Kathrin Hobron, MPH, January 2015, p. 160.
http://www.vdh.virginia.gov/medExam/Reports.htm

[2] *Id.* at 185.

I believe that the statistics regarding prescription drugs are important and cannot be overlooked because I have heard many testimonials about the progression from prescription drugs to heroin use. Parents who have lost a child to heroin have described how their child suffered an injury, was prescribed a narcotic pain reliever, became addicted and moved to heroin. Recovering heroin addicts have described being injured and being prescribed a narcotic pain reliever with little monitoring and no detoxification.

III. Change

Changes are being made in Virginia and, hopefully, we are moving in the right direction. In 2015, the Virginia General Assembly enacted statutes that address some of the concerns presented at forums across Virginia and to the Governor's Task Force on Prescription Drug and Heroin Abuse.

Section 54.1-3408 of the Code of Virginia, as amended, was expanded to allow a pharmacist to dispense naloxone or other opioid antagonist pursuant to an order issued by a prescriber and in accordance with protocols and to allow a person to possess and administer naloxone or other opioid antagonist to a person who is, or is about to, experience a life-threatening overdose. This statute also allows law enforcement officers and firefighters who have completed a training program to possess and administer naloxone.

This legislation expands earlier pilot programs. The use of naloxone by law enforcement officers and firefighters is not mandatory. The legislation specifically made it discretionary so each law enforcement agency may determine if it is appropriate for its needs and circumstances.

A concern that I have expressed about family members and friends having access to naloxone to administer to persons who are experiencing life-threatening opiate overdoses is, admittedly, not a popular one. In the pilot programs and as enacted, the persons administering

the naloxone are not required to call 911 or seek further medical attention for the person experiencing the overdose. I understand the need to have naloxone available quickly when a loved one is experiencing an overdose. However, I also see a need for intervention and treatment which cannot always be provided by a family member or friend.

Many people have expressed concerns about users being arrested if 911 is called or if the person is taken to a hospital. I understand this concern. It is hard to see a loved one arrested. However, with no evidence other than the overdose itself, it is rare for people who overdose to be charged with possession of heroin or other drugs.

To address the concern for the user being arrested and the concern for the person who calls 911 for the friend being arrested, the Virginia General Assembly enacted § 18.2-251.03, which provides an affirmative defense for simple possession charges. This section states specifically what facts have to exist before this affirmative defense can go forward.

Also, the rise in prescription drug abuse and the connections to using illicit drugs led to recommendations from the Governor's Task Force on Prescription Drug and Heroin Abuse regarding Virginia's Prescription Monitoring Program, and collaboration with medical and healthcare schools.[3]

IV. Treatment, Diversion and Incarceration

There are too few treatment programs. There are too few affordable treatment programs. There is insufficient funding for valid treatment programs. There is a stigma related to seeking treatment. Money addresses the first three problems and education can address the fourth.

[3] Recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse, Implementation Plan, June 30, 2015.

Also, treatment programs need to be funded and need to be created for people who are incarcerated. Follow up treatment has to be provided upon release from incarceration. Treatment should not and cannot exist only for those not incarcerated.

Also, there should be more diversion programs including Drug Courts in all levels of the system (Circuit, General District and Juvenile). Chesapeake has had a Drug Court in Circuit Court for several years with no additional funding. It is small but it is successful. In the Juvenile and Domestic Relations District Courts, there should be an opportunity to have Family Drug Courts to address the dynamics of family addiction issues.

In Virginia, everyone charged with a first offense possession charge is eligible for the First Offender Program. This program allows the court to withhold a finding of guilt by placing the offender on supervision for a period of time ranging from twelve months to twenty-four months. If the offender successfully completes the supervision period, then the charge is dismissed. This is provided by statute. However, not all jurisdictions have the resources to offer an effective treatment oriented supervision period. Therefore, resources are needed to make certain that offenders are doing more than submitting a urine sample.

V. Impact

C.B. was arrested in 2006 and 2007 and, in 2007, was incarcerated for violation of probation on an unauthorized use of a vehicle charge. At that time, she requested and was allowed to enter our Drug Court program. She knew and admitted that she was an addict, she had lost custody of her daughter and she "dried out" in jail. C.B. needed help and the incarceration scared her and "woke her up". She experienced a couple of setbacks in Drug Court but the immediate sanctions reinforced the concept of consequences for all her actions and choices. She successfully completed and graduated in 2009. She has been clean since then, has

regained custody of her daughter, and works full time. C.B. stays in contact with my office and thanks me regularly for "locking her up for 60 days".

While we all know people who say incarceration "woke them up" or was "their rock bottom they needed to hit", we, also, all know people who overdosed or continued to use shortly after release on bond or after serving their sentence. A defense attorney from Norfolk shared with me that he will never forget the feeling he experienced when the parents of his client called him the morning after the bond hearing where he convinced the court to set a bond over the prosecutor's objection, to tell him that their daughter died from an overdose twelve hours after they posted bond. We all know that no matter how untrue and unfair, the attorneys (both defense and prosecutor), the parents, and the court all blame themselves for a part of her death.

VI. Federal Assistance

I, and many of my colleagues across the Commonwealth, have requested assistance from the United States Attorney's Office (USAO) in prosecuting cases involving deaths resulting from the illegal distribution of narcotics (illicit and prescription) for a variety of reasons. The federal agencies have more resources than many of our jurisdictions and the federal grand jury lends itself to preparing and presenting indictments for crimes committed in multiple jurisdictions by one person or one group.

Additionally, in 2013, the Virginia Court of Appeals in Woodard v. Commonwealth, 61 Va.App. 567 (2013), held that the killing must occur in the same place as the underlying felony (the distribution) for the felony homicide statute to apply. Felony homicide is punished as second degree murder with a sentence range of 5 years to 40 years in prison with no mandatory minimum. An attempt was made to alleviate this new obstacle through legislation in 2015.

However, it failed. Therefore, the federal law has become more important to Virginia's prosecutors.

Also, the USAO has the opportunity to work with defendants after they are sentenced and transferred to a federal prison because they have the ability to continue to present to the court evidence of cooperation for a possible reduction in sentence. Under Virginia law, once the defendant is transferred to the Department of Corrections, the sentence cannot be modified.

The federal grand jury is now somewhat reflected in our state multijurisdictional grand juries which allow for longer terms and more in depth presentation of cooperating and non-cooperating witness testimony before indictment. This is helpful but the vast majority of cases prosecuted by Virginia's prosecutors are initiated by warrants and citizens expect and deserve quick action when they call the police.

Additionally, there are no state or local funds for witness protection or relocation. The Virginia State Police have a program by statutory authority but there are no funds for its operation. Our witnesses encounter the same threats and intimidation as federal witnesses and we cannot protect them. Their safety is another reason we seek assistance from the USAO.

Because of the quantity of cases and arrests made by local law-enforcement, federal funds are needed for intervention through diversion programs and treatment. Also, Virginia's prosecutors and local law-enforcement are becoming much more involved in community outreach to prevent criminal activity including drug use. Federal funds would be helpful in establishing and continuing these programs. In particular, educating the public about the dangers prescription drugs can present when used incorrectly, when used by people to whom they are not prescribed, and when accessed by small children, is costly. Not only do people need to be

educated but safe secure boxes for storage need to be provided and the disposal of unused prescriptions by incineration needs to be available to all jurisdictions on a regular basis.

VII. Conclusion

The growing heroin epidemic must be attacked through a multi-disciplinary approach. Reducing the distribution of, use of, abuse of and addiction to heroin, prescription drugs and other narcotics involves many disciplines which include law enforcement, prosecutors, pharmacists, medical doctors, health professionals, substance abuse counselors, first responders, mental health providers, addictionologists, recovering addicts, family members, and legislators to name a few. I do not know the right answer or solution but I do know that people need to be at the table for the discussion and to express their concerns, issues and perspective. Only through an open and honest discussion can the issues of education, treatment, monitoring, safe storage and disposal, enforcement and protection of society be addressed and progress made.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 34. Drug Control Act

§ 54.1-3408. Professional use by practitioners

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;

2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;

3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol; or

4. A licensed respiratory therapist as defined in § 54.1-2954 who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or any employee of a private school that

complies with the accreditation requirements set forth in § 22.1-19 and is accredited by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen for use in emergency situations; and epinephrine for use in emergency cases of anaphylactic shock.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the immediate and direct supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of a school board who is trained in the administration of insulin

and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the immediate and direct supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage,

frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day-care center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § 63.2-100 and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

O. In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § 63.2-100 and regulated by the State Board of Social Services or a local government pursuant to § 15.2-914, or (ii) a student at a private school that complies with the accreditation requirements set forth in § 22.1-19 and is accredited by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions

pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

P. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

Q. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

R. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

S. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner, or physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.).

T. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § 32.1-126.4.

U. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

V. A physician assistant, nurse or a dental hygienist may possess and administer topical fluoride

varnish to the teeth of children aged six months to three years pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry that conforms to standards adopted by the Department of Health.

W. A prescriber, acting in accordance with guidelines developed pursuant to § 32.1-46.02, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

X. Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist may dispense naloxone or other opioid antagonist used for overdose reversal and a person may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opiate overdose. Law-enforcement officers as defined in § 9.1-101 and firefighters who have completed a training program may also possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Code 1950, § 54-497; 1956, c. 225; 1970, c. 650, § 54-524.65; 1973, c. 468; 1976, cc. 358, 614; 1977, c. 302; 1978, c. 224; 1980, cc. 270, 287; 1983, cc. 456, 528; 1984, cc. 141, 555; 1986, c. 81; 1987, c. 226; 1988, c. 765; 1990, c. 309; 1991, cc. 141, 519, 524, 532; 1992, cc. 610, 760, 793; 1993, cc. 15, 810, 957, 993; 1994, c. 53;1995, cc. 88, 529;1996, cc. 152, 158, 183, 406, 408, 490;1997, cc. 272, 566, 806, 906;1998, c. 112;1999, c. 570;2000, cc. 135, 498, 861, 881, 935;2003, cc. 465, 497, 515, 794, 995, 1020;2005, cc. 113, 610, 924;2006, cc. 75, 432, 686, 858;2007, cc. 17, 699, 702, 783; 2008, cc. 85, 694;2009, cc. 48, 110, 506, 813, 840;2010, cc. 179, 245, 252;2011, c. 292;2012, cc. 787 , 803, 833, 835;2013, cc. 114, 132, 183, 191, 252, 267, 328, 336, 359, 617;2014, cc. 88, 491;2015, cc. 302, 387, 502, 503, 514, 725, 732, 752.

Code of Virginia
Title 18.2. Crimes and Offenses Generally
Chapter 7. Crimes Involving Health and Safety

§ 18.2-251.03. Safe reporting of overdoses

A. For purposes of this section, "overdose" means a life-threatening condition resulting from the consumption or use of a controlled substance, alcohol, or any combination of such substances.

B. It shall be an affirmative defense to prosecution of an individual for the unlawful purchase, possession, or consumption of alcohol pursuant to § 4.1-305, possession of a controlled substance pursuant to § 18.2-250, possession of marijuana pursuant to § 18.2-250.1, intoxication in public pursuant to § 18.2-388, or possession of controlled paraphernalia pursuant to § 54.1-3466 if:

1. Such individual, in good faith, seeks or obtains emergency medical attention for himself, if he is experiencing an overdose, or for another individual, if such other individual is experiencing an overdose, by contemporaneously reporting such overdose to a firefighter, as defined in § 65.2-102, emergency medical services personnel, as defined in § 32.1-111.1, a law-enforcement officer, as defined in § 9.1-101, or an emergency 911 system;

2. Such individual remains at the scene of the overdose or at any alternative location to which he or the person requiring emergency medical attention has been transported until a law-enforcement officer responds to the report of an overdose. If no law-enforcement officer is present at the scene of the overdose or at the alternative location, then such individual shall cooperate with law enforcement as otherwise set forth herein;

3. Such individual identifies himself to the law-enforcement officer who responds to the report of the overdose;

4. If requested by a law-enforcement officer, such individual substantially cooperates in any investigation of any criminal offense reasonably related to the controlled substance, alcohol, or combination of such substances that resulted in the overdose; and

5. The evidence for the prosecution of an offense enumerated in this subsection was obtained as a result of the individual seeking or obtaining emergency medical attention.

C. No individual may assert the affirmative defense provided for in this section if the person sought or obtained emergency medical attention for himself or another individual during the execution of a search warrant or during the conduct of a lawful search or a lawful arrest.

D. This section does not establish an affirmative defense for any individual or offense other than those listed in subsection B.

2015, cc. 418, 436.

Mr. SENSENBRENNER. Thank you very much.
Ms. Pacheco?

TESTIMONY OF ANGELA R. PACHECO, FIRST JUDICIAL DISTRICT ATTORNEY, SANTA FE, NM

Ms. PACHECO. Good morning, Chairman Sensenbrenner and Members of the Committee. Thank you for the opportunity to appear today. My name is Angela Pacheco, and I am the elected DA for the First Judicial District in New Mexico. I am here to talk to you about hope.

As a prosecutor, every day I make dozens of decisions that impact someone's life. I could sit here and tell you all the horrors associated with drug use, but as an elected official who is constantly being bombarded with the ills of society on a daily basis, wouldn't you rather hear about giving someone hope?

Our community, like so many, has experienced the ravages of heroin addiction for years. As a prosecutor, I have personally prosecuted three generations of families addicted to heroin and associated crimes. Every day in the courtroom, we see the same individuals addicted to opiates, day in and day out, who are released from custody and told to obey all laws and stay clean, with little to no treatment. And, of course, in 2 weeks, when they report to their probation officer, they will be given a urine specimen cup, told to provide a urine sample, the sample will test positive for opiates, then the person will be arrested, placed in custody, go back to the court, then is released from custody, told to obey all laws, stay clean, and the cycle continues.

We all know that the person is addicted to heroin. Of course, they will test positive. Just because someone tells them or orders them to stop using, do you really think that is going to last very long? Anyone that has ever raised children knows firsthand that you can't make someone do something unless they want to. The definition of insanity is we keep repeating the same mistakes over and over and expect a different result. That is madness.

So in 2014, Santa Fe became the second city in the Nation after the City of Seattle to implement a Law Enforcement Assisted Diversion program, referred to as LEAD, for low-level drug offenders. Our LEAD program is community policing at its best. A police officer on the streets knows his or her community. Who better than a police officer to divert someone into a program?

Let me tell you how LEAD works. A police officer is called to a local grocery store on a shoplifting call where he encounters Mary, a known heroin addict that he has arrested several times before. Instead of booking and arresting her, he offers her the LEAD program. The agreement he makes with Mary is that she must complete the LEAD application process within 72 hours. If she does, the officer will not file criminal charges on the shoplifting at the grocery store. If she agrees, the officer then contacts a LEAD case manager and arranges for the two to meet. The case manager asks Mary, "What can I do to help you? What do you need?" Then the two of them develop an action plan. They start with what are her basic needs. For example, she may need housing, child care, assistance in filling out a job application or a GED registration, whatever it takes to get her life back.

Remember, Mary has been through the system and has lost everything due to her addiction to heroin—friends, family, and children.

LEAD has a case management committee that meets every 2 weeks to discuss Mary's progress. The committee consists of police officers, prosecutors, public defenders, case managers, and therapists. Everyone is given an opportunity to provide input on Mary's progress. Everyone is in agreement that Mary will slip and there will be missteps, but Mary will have a safety net of individuals ready to support her.

Our LEAD program isn't for everyone, but it is a start for a number of reasons. It is about understanding that an opiate addiction is truly a public health issue and not a criminal matter. It is about recognizing that a person with an opiate addiction is a person, not just another statistic, not another criminal defendant for me to prosecute, but someone whose life does matter.

The twin purposes of LEAD are to save money and time. Also but more importantly, LEAD is about saving lives. LEAD is about empowering the person and giving them hope.

[The prepared statement of Ms. Pacheco follows:]

LAW ENFORCEMENT ASSISTED DIVERISION – SANTA FE

United States House of Representatives
Committee on the Judiciary
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations

District Attorney Angela Rosalina Pacheco*
First Judicial District Attorney
State of New Mexico
July 28, 2015

*The views expressed here are my own

Chairman Sensenbrenner, and Members of the Committee thank you for the opportunity to appear today. I wish to highlight my experience dealing with the opioid -- heroin and prescription pain reliever - crisis that we are witnessing today in my capacity as the First Judicial District Attorney in New Mexico **and describe a comprehensive new strategy that Northern New Mexico has engaged to more effectively address opioid-related crime.**

Scope of Opioid Crisis in New Mexico

In 2008, I was elected to serve the First Judicial District. My jurisdiction in New Mexico includes Santa Fe, Rio Arriba, and Los Alamos counties. The District has a total of 7,879 square miles with 26 persons per square mile.

Since the late 1990s, the three counties under my jurisdiction have struggled with severe opiate use and overdose. Injection drug use is an inter-generational issue in some communities. Heroin has infiltrated a culture that values family, elders and communities that are land rich and cash poor.

New Mexico's drug overdose death rate has been one of the highest in the nation for most of the last two decades. New Mexico's unintentional overdose death rate has almost tripled since 1990, and though in recent years the state has seen a decrease in rates, in 2014 overdose death rates increased 20%. [i]

Unintentional drug overdose death rates surpassed death rates due to alcohol-involved (A-I) motor vehicle crashes (MVC) in 1996 and death due to all MVC in 2007.[ii] However, funding for DWI prevention in New Mexico is approximately seven times the amount for overdose prevention. [iii] In 2007, New Mexico moved from the highest to the second highest unintentional drug overdose death rate behind West Virginia.

In 2010, New Mexico moved to 3rd highest behind West Virginia and Kentucky, and in 2013, New Mexico had the 5th highest unintentional drug overdose death rate behind West Virginia, Kentucky, Rhode Island, and Ohio. However, 2014 Office of Medical Examiner data show that New Mexico has moved back to the number two position in the number of overdose drug deaths in the US.

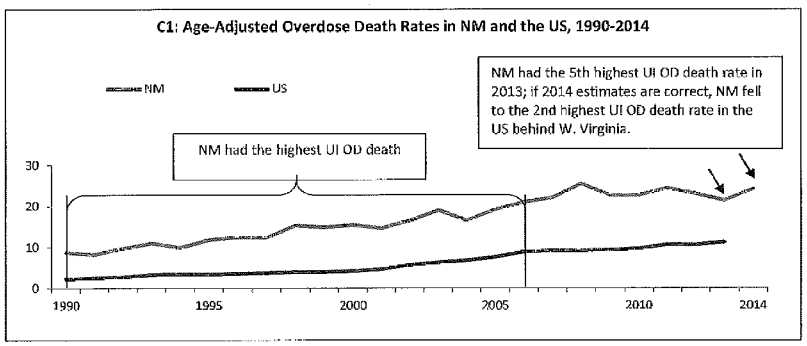

Figure C1 shows the trend in age-adjusted drug overdose death rates in New Mexico and the United States.[iv] Rio Arriba County, in my district, continues to have the highest overdose deaths in the country. In 2014, the County had a death rate of 108 per 100,000 residents, almost ten times the national rate.

In response to the opiate epidemic, New Mexico became the first state to amend its laws to make it easier for medical professionals to prescribe and dispense naloxone, and for lay administrators to use it without fear of legal repercussions. New Mexico was also the first state to amend its laws to encourage Good Samaritans to summon aid in the event of an overdose. Good Samaritan laws provide limited immunity from violations of possession of a controlled substance or paraphernalia to those who seek help for a friend or family member who is experiencing a drug overdose and call 911. Twenty-seven other states have passed a similar law to address the overwhelming rates of drug-related overdoses in their states. Furthermore, New Mexico has a well-established syringe exchange program that was built decades ago in response to very high rates of Hepatitis C infections in our state.

Just last week the New Mexico Department of Health just reported that more than 900 opioid overdose reversals were reported in 2014 due to the use of naloxone, a 29% increase in reversals from 2013. Although the increase is significant, more access to naloxone is needed in our communities. For example, not all of our Public Health Offices in every county dispense naloxone, and only a handful of law enforcement agencies carry naloxone. Only one of our county detention centers dispense naloxone when a person identified as having an addiction to an opiate is leaving the jail and only one of our jails offers medication assisted treatment to people who enter jail with an addiction.

New Mexico's overdose rate in part can be attributed to: the lack of care coordination among health care providers, substance abuse counselors, buprenorphine providers and methadone providers; a lack of medication assisted treatment services and naloxone dispensing in the jails and detention centers; no care coordination upon release for people leaving jail with an addiction; and medical providers who are over prescribing strong opioids and not informing patients about the risks of addiction and overdose or co-prescribing naloxone.

While there has been a dramatic increase in heroin and prescription drug use that has shifted from urban centers to rural areas, including communities affected in rural parts of the United States not accustomed to dealing with heroin use, authorities in my jurisdiction have been dealing with this for a long time.

We see the same nonviolent drug offenders filling the court's dockets over and over again while burdening taxpayers with expensive jail stays. While in jail these people never receive the treatment and social supports they need to address their addiction. We arrest people and then we send them to court on a felony. We tell them, "Stay clean." Within two weeks, they go in and they meet with probation and parole after giving a urine sample. The drug test will come back positive because they are still struggling with their addiction, so then we put them back in jail and we go back to court on a probation violation and we all say, "Don't use drugs."

We put them back out on the street and within a couple of weeks, they go back to probation, they have a positive drug test, then they go back to jail and we do this constantly, every day. Nobody is getting anywhere with this. I feel like a mouse on one of those little wheels. I just keep running and running and running and we're not getting anywhere.

People go through the system without any impact on their behavior. What's worse, is that once they have been in the system, the challenges they face in turning their life around are infinitely greater than they were before. Everything gets harder – from putting food on the table to keeping families together to simply keeping hope alive.

That ends up costing our community far more - in time, in human resources, in un-realized potential, in tax dollars, and in the cost of future crimes - than it would if we could catch these cases before going into the system and get these people the help they need.

Our state, our communities and our families are wrestling with addiction, overdose, incarceration that is costly in more ways than one, and rising property crimes. Not unlike our sister cities across the county, we were frustrated with the level of repeat offenders, frustrated with the predictability, and the futility, of that old, but always tragic cycle.

Arrest, trial, conviction, short stint in jail, release. Arrest, trial, conviction, short stint in jail, release. Again and again.

What we were doing wasn't working, and our community in Northern New Mexico was ready to invest in better options.

So in 2014, Santa Fe became the second city in the nation after the city of Seattle to implement a Law Enforcement Assisted Diversion program, referred to as LEAD, in an attempt to address low-level crime and reduce, where possible, the involvement of a criminal justice system that often seems stacked against poor and minority defendants.

Law Enforcement Assisted Diversion

Under LEAD, police officers exercise discretion to divert individuals for low-level criminal offenses (including drug possession and low-level sales) to a case manager and a comprehensive network of services instead of booking them and initiating the charging process. LEAD fosters true partnership between police and the communities they serve.

Santa Fe's LEAD program was developed after nine months of study and community engagement and is tailored to the community's needs. Unlike Seattle, Santa Fe's main concerns are not drug markets, but rather opioid misuse, dependence and overdose, as well as rising rates of property crime. Eligibility for Santa Fe LEAD is limited to those caught possessing or selling three grams or less of opioids.

The unique collaboration between multiple stakeholders -- including the police, district attorneys, mental health and drug treatment providers, housing providers and other service

agencies, the business community, public defenders, elected officials and community leaders – has directly contributed to the success of LEAD. Traditional adversaries have an opportunity to come together to supervise and encourage participants in the program. In so doing, they grow to have a stake in the success of the people going through the program. The results thus far have been eye-opening.

After three years of operation in Seattle, a new, independent evaluation has shown that LEAD reduces the number of people arrested, prosecuted, incarcerated, and otherwise caught up in the criminal justice system. The University of Washington evaluation found that LEAD participants were 60% less likely to be rearrested within the first six months of the study and 58% less likely to be rearrested during the entire course of the evaluation to date.[v] This result is particularly encouraging based on the high re-arrest rate for this population under the traditional criminal justice model. The Santa Fe program has only been in operation for one-year, however, early data suggests we are seeing this same decrease in recidivism.

The Santa Fe LEAD project allows us to focus on goals we all agree on: protecting our kids, increasing the public safety, and preventing and treating addiction. And, although it is too soon to paint a causal connection, I am proud to say that property crime is dropping in Santa Fe, hitting all-time lows and showing no indications of picking back up again.

LEAD recognizes that drug use is a complex problem and people need to be reached where they currently are in their lives. LEAD has precipitated a fundamental policy reorientation in Santa Fe, from an "enforcement-first" approach, to a health-centered model – reinforced by specialized harm reduction training required of every police officer. In this sense, LEAD helps people with physical and mental health needs escape the cycle of repeated arrests and incarceration for substance use.

An unplanned but welcome effect of LEAD has been the reconciliation and healing it has brought to police-community relations. While tensions rise in many communities between law enforcement and civil rights advocates, LEAD has led to strong alliances among traditional opponents in policy debates surrounding policing, and built a strong positive relationship between police officers and people on the street who are often a focus of police attention.

Benefits of the LEAD Program to the Community

- Increases safety and order for the community by reducing future criminal behavior.
- Reduces the burden on the law enforcement, county jail, prosecution, and court system.
- Redirects public safety resources to more pressing priorities, such as serious and violent crime.
- Reduces opiate overdoses and recidivism.
- Optimizes the use of the Affordable Care Act health coverage for treatment and social supports.
- Improves individual outcomes and community quality of life through research-based treatment, harm reduction and social supports

Too many times, I think we look at this massive, sometimes overwhelming justice system and we say it's too big for local communities to have an impact.

But in Santa Fe, and in Seattle, we're finding more and more every day that in spite of that sense of powerlessness, it's a misconception, and when a really good idea comes along, and circumstances in your community and the public safety demand action, you can move the mountain, and make a real difference in people's lives and in your community's public health and safety.

This was something we had to get right. So we put all the options on the table – and brought all the key stakeholders to the conversation.

City, county and Tribal officials, law enforcement, the District Attorney, public defenders, treatment providers, community groups and citizens all came together to identify a new approach to addiction and the crime that is directly correlated to it.

A few things became clear in those conversations:

- We wanted to see people who were struggling with addiction in a public health system rather than in jail or on the streets.

- We recognized that handling low-level, non-violent drug offenders in the local and state criminal justice system was not only far too costly but also far too ineffective. The evidence suggests that this is not a way to break the cycle of addiction or enhance public safety.

With the economic strain on our local counties, pre-booking diversion programs, like LEAD, offer a viable, cost effective alternative to the status quo that can positively impact our communities. In Santa Fe, LEAD is projected to cost **80% less** than the current system over a 10 year period. [vi]

Santa Fe LEAD Task Force Findings: The Cost to the System

100 individuals, arrested by City of Santa Fe Police for opiate possession or sales, cost more than **$4 million dollars** or an average of **$41K per individual** across local and state systems over the last **3 years.**

These same 100 individuals **cost the city $1 million dollars in jail/detention** costs over 3 years for a total of **11,502 jail days.**

They were **arrested 590 times** by police officers in the 3 years; officers spent an average of 9.3 hours per arrest.

A majority (91 out of 100) were repeat offenders with a pattern of being re-arrested every 6 months.

51% of those individuals had **property crime** histories.

A growing number of jurisdictions are interested in adopting LEAD including Washington D.C., Baltimore, Atlanta, Buffalo, Houston, Ithaca, Los Angeles, New York City, Philadelphia, Portland (ME) and San Francisco. Albany, NY, is on pace to launch LEAD in 2016. Numerous jurisdictions around the country are interested.

Conclusion

At some point, we have to get past the rhetoric. This isn't a question of being soft or tough on crime. There are plenty of politicians out there who tell you the answer is to crack down on criminals and then keep coming back with the same tired solutions like increasing mandatory minimums and throwing more and more Americans – members of our communities – in jail.

If we really care about fixing the problem – not just using it to further our goals, then it is time to invest in better, smarter options. It is time to listen to what the data tells us and treat drug misuse as a health issue, not a criminal one.

Santa Fe is privileged to be on the forefront of this exciting shift in criminal justice policy and we are excited to be in a position to work with other jurisdictions on implementing this model in their communities.

The police rank and file we have working this program will tell that it's changed lives for the better, and already has had an impact on our community that could last a generation or more.

This is about shifting resources so that our law enforcement officers and our prosecutors and our jail and our first responders can really respond to the violent crimes that we know exist in our community. Above all, this is a public safety program and it is a public health program.

Already, our streets are safer and our families are healthier.

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[i] New Mexico Department of Health: http://nmhealth.org/news/information/2015/7/?view=279

[ii] NM, Department of Health, Epidemiology Response Division Data.
[iii] Moeller, Shelly, *An Inquiry into Harm Reduction Policies and Practice to Prevent Drug Overdose in NM*, June 2015.
[iv] NM, Department of Health, Epidemiology Response Division Data.
[v] University of Washington-Harborview Medical Center. *LEAD Program Evaluation: Recidivism Report*, March 27, 2015.

[vi] Rand, Jookee. *LEAD Cost Benefit Analysis*, Santa Fe Community Foundation. June 24th, 2013.

Mr. SENSENBRENNER. Thank you very much.

We will begin questions under the 5-minute rule, and I will yield myself 5 minutes to ask the first series of questions.

Ms. Pacheco, I agree with you that merely throwing somebody in jail and then having them come out and probably go back to the bad ways that got them to jail in the first place is something that ought to be addressed. Can you give me an estimate of the recidivism rate of those who have gone through the LEAD program and graduated and ended up finding out—everybody finds out that it didn't work?

Ms. PACHECO. Certainly. Mr. Chairman, Santa Fe's program has been in existence for 1 year and, as such, we don't have the kind of statistical data that, let's say, Seattle does. Seattle has shown that in their program—and Santa Fe is modeled after it—the recidivism is—I want to make sure I have the correct number for you. I had it marked here for you. I am sorry, sir. It would be 80 percent less, Mr. Chairman.

Mr. SENSENBRENNER. It is 80 percent less than the recidivism rate before the program started in Seattle?

Ms. PACHECO. Correct.

Mr. SENSENBRENNER. Well, let me say that I think this is probably the most important thing that we ought to look at, because as demand goes down, the profits that are made by the dealers go down as well, and we can talk about saving lives and giving people hope. In my home community in Southeastern Wisconsin, we have had a rash of deaths as a result of heroin overdose. Attorney General Brad Schimel of Wisconsin last week convened a task force to try to deal with this both from a law enforcement as well as a treatment and rehabilitation standpoint, and the bill that I introduced with other Members of the Committee was made at the suggestion of Governor Walker.

What advice would any of you give to the Attorney General of Wisconsin on how to deal with the task force that he has convened so that it can be effective, and why don't you start, Mr. Botticelli?

Mr. BOTTICELLI. One of the areas that I think you have heard today—and we have been working with many, many states and Attorneys General in terms of helping with state responses to that. I think the overall goal is that this has to be a comprehensive response, that people know, quite honestly, that it is a multi-dimensional problem that needs a multi-pronged approach. So prevention, treatment, recovery support services, as well as a role for our local law enforcement too in terms of not about incarcerating people with addiction but going after the supply of drugs that are on our streets that are fueling this epidemic. So it really needs to be a multi-pronged approach.

As you mentioned, as I think many local law enforcement people are understanding the fact that they can't arrest their way out of this problem, and that they also have a role in terms of reducing overdoses. So we have really been, I think, amazed in terms of local law enforcement's rise to the call in terms of preventing overdoses.

But this is really a multi-dimensional issue here that requires a comprehensive response. Everybody, as Mr. Riley talked about, has a role here. So whether that is law enforcement, the public health community, faith leaders, it is about bringing people together, look-

ing at the evidence about what is effective, and implementing those responses.

Mr. SENSENBRENNER. Ms. Parr, do you have anything to add to what Mr. Botticelli has said?

Ms. PARR. Well, Mr. Chairman, I am serving on the Governor's Task Force on Prescription Drug Overdose, and I can say that one of the good things and the reason I think this task force is working and the implementation plan has been published is that there are so many different aspects. We have pharmacists, we have medical doctors, we have mental health treatment providers, we have law enforcement, we have state police, local police, sheriffs. The Federal Government has a representative there. We are all represented there, and it has been broken down into a treatment workgroup, a law enforcement workgroup, education, and also more specific on disposal, safe disposal of the prescription drugs. So the broad spectrum, and then breaking down into specific workgroups I think has produced a very good plan.

Mr. SENSENBRENNER. Thank you very much. My time is up.

The gentlewoman from California, Ms. Chu.

Ms. CHU. Yes. Ms. Pacheco, I am so impressed by the LEAD program. Could you describe how the LEAD program has affected police and community relations in Santa Fe and what role the community involvement plays in LEAD, as well as what cost savings have been realized by implementing this program?

Ms. PACHECO. Thank you, Mr. Chairman, Ms. Chu. Initially, Santa Fe had a series of meetings by all community members for about 9 months. We did a needs assessment. Everybody was involved—private business, law enforcement, mental health workers—and we were able to put together the LEAD program.

The LEAD program consists of a consortium of individuals, Santa Fe County, the City of Santa Fe, Santa Fe Police Department and the District Attorney's Office, the Public Defender's Office. All of us get together and we have combined resources, manpower. We have public funding, we have private funding, and we get together, and I guess what I would really like to say is it is really wonderful to see how the police officers have responded to this.

The police officers on the streets are the ones who originally came to us and said we need to do something, we are sick and tired of arresting the same people, we have nothing we can give them, and for us it has been very gratifying to see the response by the police department.

Then the other thing that has been very gratifying to us in reference to the program has been that we have seen many young women with children, and we had not anticipated that. So we are also able to provide services to the children, and we really at first had not taken that into consideration. So what we are able to do now is provide services to an entire family, and we have found that to be very gratifying.

Ms. CHU. Thank you.

Mr. Riley, there have been numerous cases across the country where individuals who suffer chronic pain have faced challenges getting their properly prescribed pain medication. I understand that drug stores have been tightening the rules after the DEA has

imposed record fines on pharmacies based on allegations that they weren't scrutinizing questionable prescriptions.

I believe a careful balance has to be struck between attacking prescription drug abuse while not preventing legitimate patients from accessing pain medications. That is why I am a co-sponsor of H.R. 471, which is the Ensuring Patient Access and Effective Drug Enforcement Act, which passed the House in April.

So, Mr. Riley, what steps is the DEA taking to ensure that patients are getting legitimate prescriptions for drug abuse, and how do you respond to comments that the DEA's actions to stop prescription drug abuse are causing an increase in the heroin abuse problem?

Mr. RILEY. Thank you, ma'am. I too share the concern on this. We are so concerned about patient access at every step, and we want to ensure that a legitimate health care provider has access to adequate medication for their patients.

One of the biggest ways that we are doing that now is our relationship with the industry. There are approximately 1.5 million registrants. Of those, about 900,000 are physicians. By obviously communicating back and forth with them and making sure that they understand what we are seeing across the country and trends of addiction and abuse has really brought them in and what we strive to do to make them our allies.

So our education of how they view the problem is really important, and clearly we want to listen from the registrants so it is a two-way street. If you look at, for instance, what occurred in Florida with the pill mill situation of several years ago where literally you had a storefront, a small strip mall with several hundred people lined up around the block at 6 a.m. waiting for it to open to obtain obviously illegal prescriptions, in those situations, ma'am, we move very quickly to cut that off.

Of the 1.5 million registrants, obviously the vast majority are law abiding, but the ones that choose to break the law we take very seriously. But what we really strive for is patient access, safe and accessible medication.

Ms. CHU. Thank you.

I yield back.

Mr. SENSENBRENNER. The gentlewoman's time has expired.

The gentleman from Virginia, Mr. Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. Riley, the map you brought paints a distressing picture. It suggests that drug trafficking organizations, especially the Sinaloa Cartel, have infiltrated our Nation to a pretty frightening degree and have partnered with street gangs in this country to pedal their drugs. In many ways, it is a national security issue. What is the DEA doing to address that particular problem?

Mr. RILEY. Thank you, sir. That is my primary, biggest concern, having seen this change. This map that you are looking at would have been vastly different just 5 years ago. The role of heroin, the toxic business relationship that has evolved in virtually every corner of this country between urban street gangs and Mexican cartels is frightening to me. It is what keeps me up at night.

What we are doing better than we have ever done, sir, is connecting the dots. I can tell you that Chapo Guzman, for one, counts

and plans on the fact that cops don't talk to cops, that the good guys aren't sharing information, and I can assure you we are doing that better now.

So our ability to attack organizations and their tentacles as they begin to spread across the country has never been better.

Mr. GOODLATTE. Are these drug trafficking organizations by their nature violent?

Mr. RILEY. There is no doubt in my mind, having done this job in cities across the country for 30 years, I have never seen violence connected to trafficking——

Mr. GOODLATTE. Are these the people you are targeting?

Mr. RILEY. Many of them are parts of organizations that are extremely violent.

Mr. GOODLATTE. How many drug possession offenders, meaning those who possess only enough for personal use, does the DEA refer for Federal prosecution?

Mr. RILEY. In my experience, virtually none. Our goal is to attack the highest levels possible so that we can really hurt the organization from start to finish. With our limited resources, sir, that is the most effective way for us to make a difference across the country.

Mr. GOODLATTE. Let me turn to Ms. Parr and Ms. Pacheco and ask a similar question.

Ms. Parr, is violence regularly associated with drug trafficking and distribution?

Ms. PARR. Mr. Chair, yes, I would definitely agree with that statement. We have seen in Chesapeake, which is a very safe community, our shootings are mainly between gangs who are fighting over turf, where they are going to sell their drugs.

Mr. GOODLATTE. What kind of violence do you see associated with heroin use and distribution?

Ms. PARR. With heroin use?

Mr. GOODLATTE. And distribution.

Ms. PARR. With the heroin use, the violence is not so much. It is more the property crimes for heroin users because they are stealing to support their habits. We have seen an increase in prostitution in Chesapeake because that is the way some women are making the money to support their habits.

As far as distributing the heroin, again that would be the gun battles that are on our city streets and in our neighborhoods that expose innocent people to the gunfire.

Mr. GOODLATTE. Does it extend into gang violence over turf?

Ms. PARR. Yes.

Mr. GOODLATTE. Sales territory, if you will?

Ms. PARR. Yes. We have gangs in Chesapeake, in all areas of Chesapeake. We have over 300 square miles, and there is a lot of turf to fight over, and when they see an opening, they are going to go there.

Mr. GOODLATTE. And is there a nexus between heroin trafficking and other criminal acts by these drug organizations or gangs?

Ms. PARR. Yes, sir. Whenever you have the trafficking, the drug trafficking, then you are also going to see an increase in the prostitution that is coming into the area, and also robberies. I mean, we have gang members robbing other gang members, drug dealers robbing and shooting other gang members.

Mr. GOODLATTE. Thank you.

Ms. Pacheco, do you want to respond to the same? Is violence regularly associated with drug trafficking and distribution?

Ms. PACHECO. Yes, sir, it is, and it has become worse.

Mr. GOODLATTE. And what kind of violence do you see in New Mexico?

Ms. PACHECO. There have been many shootings.

We have had a few executions as a result over trafficking.

Mr. GOODLATTE. Do you have the same problem with the nexus between gangs and the drug organizations? The gangs are their local sales organizations, if you will, for the Sinaloa Cartel and other drug distribution organizations?

Ms. PACHECO. We definitely are aware of the fact, because we are a border state. We definitely see heroin coming in from Mexico fairly frequently, especially in Northern New Mexico. I couldn't say specifically which cartel it is associated with, but we definitely see a lot of drugs coming in from the border, sir.

Mr. GOODLATTE. Thank you very much.

Thank you, Mr. Chairman.

Mr. SENSENBRENNER. Thank you very much.

The other gentleman from Virginia, Mr. Forbes.

Mr. FORBES. Mr. Chairman, thank you.

Ms. Pacheco, we are looking at these programs to stop recidivism. Did your organization or have you done any studies to look across the country at the faith-based programs that have worked incredibly successfully in trying to stop recidivism? Have you all done an analysis of that? And specifically, have we looked at their success rates and also impediments that we are now putting in front of them to stop them from doing some of the work that they are doing? Did you all make any kind of investigation of that?

Ms. PACHECO. Not really, sir. This is—LEAD is a fairly new concept and there really isn't another model to compare it to.

Mr. FORBES. The only thing I would say is this. Oftentimes, we love to create new wheels and reinvent the wheel, but we have had some incredibly successful programs around the country that we have put one impediment after the other to them doing a complimentary role with what you are doing. At some point in time, we need to take a look at that and analyze that.

Mr. Riley, let me ask you this question, following up on the Chairman's statement. You know, we have had testimony in here that today if we look across the country, the gang membership in this country would equal the fourth largest army in the world. And we have also had testimony—and this is both Administrations, not a push on just one—that in some of the most violent gangs that are serving as these networks, that at least 85 percent of them are coming in here illegally. So they are bypassing any prevention programs or anything that we are doing, getting into these gangs. It shocked us the other day to find out the Secretary of Homeland Security didn't even know if we were asking people if they were members of violent gangs before we released them.

Do you have any connectivity as to just how important those gangs are in this distribution process?

Mr. RILEY. Sir, I think they have become almost crucial to the Mexican cartels. Speaking just for Chicago and the Midwest, there

are over 150,000 documented street gang members. Largely they make their living from putting drugs on the street, supplied by the cartels. Heroin is now their drug of choice, and the way that they regulate themselves, sir, is by the barrel of a gun.

So this is an enormity in terms of what we are seeing across the country, and it is extremely toxic. And that is why it is really important for law enforcement to be involved, to attack the organizations, not just what is occurring on the street. Obviously, we will work with our state and local counterparts to intervene in violent acts, but to make sure that the integrity of those cases are worked to the highest level so that we can have an impact on the organization itself and the community.

Mr. FORBES. And this Committee has worked to do that. Chairman Sensenbrenner actually got some pretty sophisticated gang legislation out of here. Unfortunately, it got bogged down in the Senate and we couldn't see it come out.

Ms. Parr, let me ask you and Mr. Riley this question. On July 14th, five individuals from Portsmouth and Chesapeake were arrested on Federal conspiracy charges of manufacturing, distributing and possession with intent to distribute heroin as part of an investigation led by the FBI's Norfolk Field Office and Chesapeake Police Department. According to court documents obtained by a local news channel, the investigation involved 75 kilograms of heroin sold between 2013 and 2015.

To put that in perspective, that is equivalent to over 2 million doses, which is enough to give everyone in Hampton Roads a high off of heroin.

With that said, can you give us any details about those arrests, or more particularly the level of coordination between local, state, and Federal Governments? And were there any barriers that you would suggest were problematic that we could work on eliminating for you?

Ms. PARR. Mr. Chair, that recent arrest I think is a prime and great example of the cooperation that we have in South Hampton Roads, particularly between Chesapeake, Portsmouth, Suffolk, and the U.S. Attorney's Office, the DEA, and FBI. We have worked together quite well on many cases.

In this case, I did not see any obstacles as everybody was fully aware of what was going on as far as the investigation was going, and it was very well organized as to the execution of the search warrants.

You did state the amount of heroin and the money that they were making off of this. One thing I would like to point out, though, is that in one of those homes where there was a search warrant executed in Suffolk, there were many children in that home, and the information is that $50,000 was counted every other day in that house with those children there because of the heroin sales, and that heroin was cut and prepared on the dinner table. I think that when we look at that and we look at the children who were exposed to this, we have got to do something.

Mr. FORBES. Thank you. My time has expired, but I can talk to you another time about that.

I yield back.

Mr. SENSENBRENNER. Thank you.

The gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

Special Agent Riley, I want to thank you for your service and bring to your attention the excellent work of the DEA agents in the upstate of South Carolina who are a credit to your agency.

I am not very good with math, which means I am in the right line of work, so I need you to help me a little bit. I think that it takes 28 grams of cocaine base to trigger the mandatory minimum, the 5-year mandatory minimum?

Mr. RILEY. I believe that is true.

Mr. GOWDY. And 28 grams of base would be roughly equivalent to 112 dosage units, I believe, assuming .25 grams for a dosage unit. So to get 5 years mandatory minimum in prison, you need 112 dosage units of cocaine base or crack cocaine.

Mr. RILEY. Yes, sir.

Mr. GOWDY. All right. And it takes 500 grams of powder to reach that same 5-year mandatory minimum, which would be about 500 dosage units, because it is about a gram a dosage unit when you are dealing with powder.

Mr. RILEY. Yes, sir.

Mr. GOWDY. Now, heroin, it takes 100 grams, I believe, of heroin to reach that same threshold, but that is 3,000 dosage units. So why could you go to prison for 5 years for 112 dosage units of crack cocaine, but 3,000 dosage units of heroin is what it takes to trigger that 5-year mandatory minimum? That just seems absurd to me.

Mr. RILEY. Well, clearly, on the law enforcement side, we are cops.

Mr. GOWDY. Right.

Mr. RILEY. We are doing the best we can with the laws that are currently out there.

Mr. GOWDY. You are, which is why, when there is a discussion about reforming mandatory minimums, it is important to hear from law enforcement officers.

One thing we could do is just equalize what it takes to trigger a mandatory minimum. I mean, if you are having a problem with heroin and it requires 3,000 dosage units to reach that 5-year threshold, but it only takes 100 dosage units of crack cocaine, it is pretty easy even for me to see that one thing that could be done with respect to heroin.

I know folks, everybody in Congress doesn't like mandatory minimums. Most folks in law enforcement like them, but everybody in Congress doesn't like them. But I want to ask you this: How many folks are serving Federal prison sentences for simple possession of a drug?

Mr. RILEY. I have been doing this for 30 years, and I can tell you, nobody as a result of my investigations.

Mr. GOWDY. Yes, I couldn't find any either. I haven't done it as long as you. I couldn't find anybody sitting in a Federal prison for simple possession of a controlled substance.

How about—here is another phrase I hear from time to time—low-level, non-violent drug offenders? How many of those did you target for investigation when you were a DEA agent?

Mr. RILEY. None, sir.

Mr. GOWDY. Right. DEA wouldn't target low-level, non-violent drug offenders. They would go to the state prosecutor, right?

Mr. RILEY. No, sir. We would go after the largest traffickers we could identify and the largest organizations.

Mr. GOWDY. Right. So this mythology that our Federal prisons are full of low-level, non-violent offenders, the statistics and your 30 years in law enforcement simply just doesn't bear that out, do they?

Mr. RILEY. Not based off the investigations that I was involved in.

Mr. GOWDY. I have a colleague who was a prosecutor in a former life, Joe E. Kennedy from Massachusetts, a very conscientious colleague from the very first day he set foot in Congress, who shared with us his concern about the heroin epidemic, and he wanted and has asked in the past about the interconnectivity, the relationship between prescription drugs and heroin. Who can speak to that on behalf of my colleague, Mr. Kennedy, who raises a pretty good question?

Mr. BOTTICELLI. And I think it is a real concern here that, as we talked about before, four-fifths of the new users to heroin started using prescription pain medication, and because of some of the economics of what it costs to buy a prescription pain medication on the street versus how cheap pure heroin is, we see that transition. I think this is where intervention and treatment and diminishing the vast over-prescribing of prescription pain medication that is happening right now is particularly important in terms of our efforts.

Mr. GOWDY. Quickly; I have 25 seconds. Drug court, tremendous believer in drug court, saw lives changed. But heroin is hard to get off. In fact, it was the hardest drug for folks to quit back in my previous job. So what do we need to do with heroin to make it where more folks are getting off of it through drug courts?

Mr. BOTTICELLI. Coincidentally, I just spoke this morning at the National Association of Drug Court Professionals, 5,000 people from across the country who are literally saving lives by giving people a second chance, by giving them good care and treatment with accountability.

Part of what we know to be effective, particularly for people with heroin use, is that medications, when combined with other therapies, become critically important, and the evidence that people with opiate addiction or prescription drug addiction without medications fail a significant portion of the time.

So we have actually been working with our treatment programs, with our drug courts, and using our Federal resources to support increased access to these medications as part of a comprehensive strategy in terms of what we know to be the most effective treatment for people with opioid use disorders.

Mr. GOWDY. Thank you, Mr. Chairman.

Mr. SENSENBRENNER. The gentleman's time has expired.

The gentleman from Michigan, Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chair. And thank you to the panel. I appreciate your testimony today on this very important issue.

As a former local prosecutor myself, I had an opportunity to prosecute many drug-related offenses. But I can tell you, in my experience, I never saw this level of heroin in the marketplace. It is trou-

bling, especially as I have school-age children and I hear too many stories. It is very disconcerting for a parent and someone like me who is in elected government looking for solutions, and I appreciate your willingness to be a part of the solution-making process.

I recently met with a group of local law enforcement officers, my local county sheriffs and several others, to talk about the issue. Sheriff Bouchard, and also our sheriff in Livingston County, and the statistics that they shared are alarming, and they have piqued my interest, and I want to do whatever I can to be a part of the solution.

In Livingston County, they had 34 heroin overdoses that resulted in deaths last year alone. In Oakland County, they used to have between 40 and 45 heroin-related overdoses per year. But last year, over the past 2 years I should say, that number has increased to an average of 200. In Ingham County, the other county that I represent, which includes the capital of our state, Lansing, they had 28 heroin-related deaths last year. That is a number that has increased every year exponentially.

So I would agree that this issue is one that deserves our immediate attention, and I want to thank the Chairman of this Committee, the main Committee, Chairman Goodlatte, and the Chairman of the Subcommittee for raising these issues and making sure that we identify these as primary concerns and that we do whatever we can to address them.

But, Director, I would like to start with you, if I could. It is clear from what I am hearing in my district that this issue cuts across all kinds of demographic lines. What are we doing to ensure that the response to this epidemic is comprehensive and holistic? Are we engaging with these local leaders, local law enforcement? When I was a local prosecutor, we had all kinds of collaborative efforts between local law enforcement and DEA, and I appreciate your comments about drug courts and alternative sentencing that is available. Can you share with us a little bit more about what you are doing?

Mr. BOTTICELLI. Sure. I think we obviously acknowledge the fact of why we can have a Federal response. Really, it is state and local responses where the rubber meets the road. It is an obligation of our office to make sure that states and locals have the resources that they need to be able to do the work and to identify the issues and to work collaboratively at the state and local level.

So we have a number of initiatives. In addition to Federal treatment funding, we also support through our high-intensity drug trafficking areas, which our counties designated as drug trafficking areas to work with state and local law enforcement to share intelligence, to go after cases. Many of them are focused on heroin issues. And I will say that many of our programs are also continuing to support prevention and education programs as well. So they try to work across the spectrum.

Our office also supports what is called drug-free community programs, and these are programs and grants to support community-based, locally-driven prevention programs at the local level, because every community looks different, but every community needs to have all of the key players on board as part of the solution.

So we really acknowledge and try to continue to support state and local efforts because we know that we can do as much as we can at the Federal level, but it also requires state and local partnership to make it really real.

Mr. BISHOP. Thank you, sir.

Mr. Riley, in your testimony, you didn't make reference to this but I am wondering if you can share with me legalization of marijuana at the local and state level. Can you tell us how that is influencing these markets and whether or not that has led to the increase in heroin in our country, and if it has shifted the focus away from marijuana and we are focused now on methamphetamine, heroin, and other types of drugs?

Mr. RILEY. Well, I think it goes to really the market genius of the cartels in particular. They have seen, and I do believe they have seen the spread of prescription drug abuse, and they know that at some point that availability does cease. Thus begins that long road to heroin, and we have seen that across the country. So I believe it is much as it was 10 years ago when we were battling methamphetamine. With the help of Congress, we were able to legislate primary precursors out, pseudo-ephedrine and ephedrine, and we saw a drastic reduction in the amount of domestic laboratories.

However, the cartels recognized that there still was a tremendous addiction issue. So, what did they do? They were able to produce methamphetamine in 50- and 100-pound cooks and provide that to the areas in which previously had been supported domestically. So as I look at this problem, sir, I think it truly is battling the new face of organized crime, and I am so glad the Committee recognized what has been troubling me for a while, the connection between domestic street gangs and the cartels. It truly is the new face of organized crime as I see it in this country, and law enforcement needs to be fluid enough to adapt to attack that relationship, because by doing that we can solve violence on the street but at the same time attack the organizations that are responsible for all the drugs.

Mr. SENSENBRENNER. The gentleman's time has expired.

The gentleman from Idaho, Mr. Labrador.

Mr. LABRADOR. Thank you, Mr. Chairman.

I would like to thank all the witnesses for being here today and for your important testimony on the rise of heroin use across the United States.

One area of particular concern that I have that I would like to address is the expanded population of heroin users. Mr. Riley, in your written testimony you mention that in 2013 169,000 people over the age of 12 used heroin for the first time within the past year, with the average age of first-time users at around 25 years old. You also cited data that indicated that of those heroin initiates, as they are called, 86 percent of them were prior prescription drug users.

I understand that your agency is developing a task force to confront the use, abuse, and trafficking of heroin in America, but what specifically is being done to address the rise in addiction from prescription drugs?

Mr. RILEY. Well, sir, I think what we are doing today is important. Awareness is really important. Prior to leaving Chicago, I attended a meeting about 2 years before I departed and there were about 100 concerned people in the room. I attended that same meeting 3 years later and there were over 2,000 people concerned with the whole heroin issue, and unfortunately many of them were parents. What strikes me most is many of these parents had no idea their kids—and I am talking high school-age kids—were involved with prescription drug abuse which led to heroin, and many of them didn't find out until they were on their way to the emergency room.

So law enforcement attacking the organizations, sir, is crucial, and that is what we do around the clock. And I have to tell you, we are doing great work. But the awareness of everybody in the community to this issue is really going to strengthen us as we go after these organizations.

So when we look across the board to parents, educators, community leaders, faith-based practitioners, everybody plays a role. While we will do our job going after the bad guys, we can't do it alone. We need the help of everybody, especially parents.

Mr. LABRADOR. Excellent. I understand many of these users are initially receiving prescription drugs through legitimate means, leading to an increase in usage among traditionally untouched populations. What does the agency propose for addressing the fundamental problem of addiction?

Mr. RILEY. Well, clearly we are working with a variety of different agencies to try to get the word out. Also, one of the problems we faced—and again, it is an awareness issue—is today's heroin on the street is being smoked and snorted initially. So initially, gone is the fear of AIDS or hepatitis because of a needle. So we are seeing a lot younger people try heroin almost as a recreational drug. The statistics show that they eventually will go to needle use, but I think it does have a lot to do with why we are seeing younger and younger addicts.

Mr. LABRADOR. Mr. Botticelli?

Mr. BOTTICELLI. Congressman, if I could add to those comments. To your point, focusing on the prescription drug problem is a top priority. First and foremost, we really need to reign in over-prescribing of prescription pain medication. Our office has proposed mandatory continuing medical education for every prescriber. Again, we want a balanced approach. We want to make sure people are getting appropriate pain medication. We don't want the pendulum to swing to the other way, and that is why we want to make sure that every prescriber has at least some minimum education about safe prescribing practices.

We know that about 70 percent of people who start misusing them are getting them free from friends and family, and that is why Federal and local take-back programs to get the drugs out of people's homes becomes equally important.

We have also been promoting prescription drug monitoring programs that allow physicians to check databases to see if someone might be going from doctor to doctor to be able to intervene at that point, as well as law enforcement responses. We just got briefed by the DEA in terms of a huge takedown in terms of bad doctors and

bad practices in the south. So we know that this needs a holistic response.

Mr. LABRADOR. Thank you very much.

Ms. Pacheco, you also mentioned the need for sentencing reform to address low-level, non-violent offenders who end up in jail with mandatory minimum sentences with no alternative for addressing their problems. I agree that mandatory minimums have proven destructive in addressing drug crimes and have resulted in wasting valuable resources. In your view, what is the best alternative for addressing addiction and the causes of drug abuse, given your experiences where drug addiction abuse is pervasive within the culture?

Ms. PACHECO. I have been doing this for many, many years, sir, and it always comes down to resources and money for drug treatment. But we see over and over the same people in and out, in and out, without appropriate resources. New Mexico, as you know, is one of the poorer states. We don't have the type of tax base to provide services. But a program like LEAD, for example, it is pre-arrest, pre-booking that shows it can save us money, and that money then can go into treatment and the wrap-around services that many of these individuals need, because that is kind of where it is at.

Someone who is in the cycle of addiction, they need as much support as possible, and that is kind of what we are doing. We are transferring resources from the back end to the front end to help them and to keep them out of the system, sir.

Mr. LABRADOR. Thank you.

Mr. SENSENBRENNER. The time of the gentleman has expired.

This concludes today's hearing, and thanks to our witnesses for attending.

Without objection, all Members will have 5 legislative days to submit additional written questions for the witnesses and additional materials for the record.

And without objection, the hearing is adjourned.

[Whereupon, at 11:21 a.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Questions for the Record submitted to John (Jack) Riley, Acting Deputy Administrator, Drug Enforcement Association*

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON THE JUDICIARY
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http://www.house.gov/judiciary

September 16, 2015

Mr. John ("Jack") Riley
Acting Deputy Administrator
Drug Enforcement Administration
U.S. Department of Justice
Washington, DC 20530

Dear Mr. Riley,

The Committee on the Judiciary's Subcommittee on Crime, Terrorism, Homeland Security, and Investigations held a hearing on "America's Growing Heroin Epidemic" on Tuesday, July 28, 2015 in room 2141 of the Rayburn House Office Building. Thank you for your testimony.

Questions for the record have been submitted to the Committee within five legislative days of the hearing. The questions addressed to you are attached. We will appreciate a full and complete response as they will be included in the official hearing record.

Please submit your written answers by Wednesday, October 28, 2015 to Scott Johnson at Scott.Johnson@mail.house.gov or 2138 Rayburn House Office Building, Washington, DC, 20515. If you have any further questions or concerns, please contact or at 202-225-5727.

Thank you again for your participation in the hearing.

Sincerely,

Bob Goodlatte
Chairman

Enclosure

*The Committee had not received a response to these questions at the time this hearing record was finalized and submitted for printing on November 17, 2015.

Questions for the record from Representative Mike Bishop (MI-08):

1. Does DEA publish public materials that provide guidance to registrants and its field offices on its inspection processes and compliance issues? How do you respond to GAO's finding that there is a lack of consistency among DEA field offices and that existing pharmacy guidance may not be clear even to some DEA field office officials?

2. Despite decades of DEA enforcement actions, it seems that the drug abuse problem continues unabated, whether the problem is heroin, cocaine, morphine, oxycodone, hydrocodone, etc. Don't you think it is long past due to take a step back and bring together a wide variety of stakeholders to agree upon new solutions to combat drug abuse?

3. GAO issued a report yesterday that found that DEA does not adequately communicate with its registrants. Don't you think better communication with registrants would help with efforts to stop prescription drug abuse? Don't you think inadequate communication leads to perceptions that all DEA cares about are the numbers of enforcement actions and not about real solutions to stop drug abuse?

4. Can you explain DEA's efforts to educate physicians about the corresponding responsibility of pharmacists under the CSA? If I understand correctly, the CSA requires a pharmacist, prior to dispensing any controlled substance, to determine if the prescription complies with all legal and regulatory requirements, and whether the prescription has been issued for a "legitimate medical purpose" "by a prescriber acting in the usual course of his or her practice. Simply put, this means that pharmacists are required to perform due diligence on each controlled substance prescription before dispensing the medication – this may mean calling back the physician to obtain or confirm certain information before the prescription can legally be dispensed. Yet, it seems that some physicians are unaware of this federal requirement – so written guidance and education seems appropriate. Would you agree with GAO's findings that more agency education should be done?

5. If questions arise during the DEA inspection process, is there a transparent and formal procedure to provide written agency feedback?

6. I am hearing that DEA actions are causing great difficulties for legitimate patients that are not able to access the medications they need to manage chronic pain. According to DEA's website, "the mission of DEA's Office of Diversion Control is to prevent, detect, and investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate sources while

ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs." How does DEA ensure that its regulatory and enforcement actions are not having the unintended consequences of causing harm to legitimate patients? Does DEA meet with chronic pain patient groups and others to ensure that the agency understands the needs and concerns of patients?

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