

CHALLENGES AND SOLUTIONS IN THE OPIOID CRISIS

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CHALLENGES AND SOLUTIONS IN THE OPIOID CRISIS

TUESDAY, MAY 8, 2018

HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
Washington, DC.

The committee met, pursuant to call, at 10:00 a.m., in Room 2141, Rayburn House Office Building, Hon. Bob Goodlatte [chairman of the committee] presiding.

Present: Representatives Goodlatte, Sensenbrenner, Smith, Chabot, King, Gohmert, Marino, Collins, DeSantis, Buck, Ratcliffe, Gaetz, Johnson of Louisiana, Biggs, Handel, Rothfus, Nadler, Lofgren, Jackson Lee, Cohen, Johnson of Georgia, Deutch, Bass, Richmond, Cicilline, Swalwell, Lieu, Raskin, Jayapal, and Demings.

Staff Present: Shelley Husband, Staff Director; Branden Ritchie, Deputy Staff Director; Zach Somers, Parliamentarian and General Counsel; Anthony Angeli, Counsel, Subcommittee on Crime, Terrorism, Homeland Security, and Investigations; Joe Graupensperger, Minority Chief Counsel on Subcommittee on Crime; Monalisa Dugue, Minority Deputy Chief Counsel, Subcommittee on Crime, Terrorism, Homeland Security, and Investigations; David Greengrass, Minority Senior Counsel; and Veronica Eligan, Minority Professional Staff Member.

Chairman GOODLATTE. Good morning. The Judiciary Committee will come to order, and, without objection, the chair is authorized to declare recesses of the committee at any time. We welcome everyone to this morning's hearing on challenges and solutions in the opioid abuse crisis. I will begin by recognizing myself for an opening statement.

America is in the middle of an epidemic it has never seen before. The opioid crisis knows no bounds. It is affecting individuals and families in every congressional district. Its consequences, ranging from personal health to the economy, are devastating. The opioid epidemic represents the convergence of the abuses of opioids, heroin, and synthetic drugs like fentanyl. Individuals suffering from addiction often switch between using opioids and heroin, based on a variety of factors including cost and purity.

Drug traffickers are further exploiting personal misery by adding deadly fentanyl analogues to the heroin and the illicit opioid supplies to increase their profits. Sadly, unwary and unsuspecting users are suffering deadly results. More frequently, pure fentanyl analogues in the illicit drug supply are resulting in overdose deaths

and injuries to first responders. Since these analogues can be deadly in quantities as little as two milligrams, police and other first responders can unknowingly inhale airborne fentanyl or have it come in contact with their skin, causing them to overdose and suffer other severe reactions.

Tragically, more than 64,000 Americans died from drug overdoses in 2016. The sharpest increase occurred among deaths related to synthetic opioids, with over 20,000 overdose deaths. Not only has the total number of opioid pain relievers prescribed in the United States skyrocketed in the past 25 years, but recently studies have shown that over half of chronic prescription drug abusers receive the pills from friends or family. In 2018, more than 2 million Americans will suffer from addiction to prescription or illicit opioids.

Over the past 2 years, the House Judiciary Committee and Congress have passed several bills to address the opioid crisis. These bills include the Comprehensive Addiction and Recovery Act, or CARA, enacted in July of 2016, and the Stop Importation and Trafficking of Synthetic Analogues Act, or SITSA, approved by the House Judiciary Committee in July of 2017. While much work has been done, we must redouble our efforts to turn the tide in this crisis.

We know now more than ever that a crisis like this requires dynamic and outside-of-the-box solutions. Today's hearing will examine what is working and what needs to be looked at again in the opioid crisis. We will learn about best practices in international and domestic enforcement, and promising solutions in treatment and prevention. We will also hear about the devastation ravaged by this epidemic from a firsthand perspective.

I want to thank all of our witnesses for appearing today and I look forward to hearing their responses to our questions. And it is now my pleasure to recognize the ranking member of the Judiciary Committee, the gentleman from New York, Mr. Nadler, for his opening statement.

MR. NADLER. Thank you, Mr. Chairman. I welcome today's hearing as an opportunity to explore ways in which we can best address the crisis of opioid abuse in our country. I believe it is critical that we do so in order to identify what works and what does not work, so that we do not repeat mistakes we have made in the past.

In the United States, drug overdoses are the leading cause of accidental death. With opioids being involved in nearly two-thirds of overdose deaths. Overall, the number of drug overdose deaths has nearly quadrupled over the past 20 years. Although effective for the treatment of pain, prescription opioids are highly addictive, and nearly half of all U.S. opioid overdose deaths involve a prescription opioid. Deaths related to heroin have similarly increased, as individuals often transition from more expensive prescription opioids to cheaper heroin.

As this crisis has intensified, Congress has contemplated various responses, and, in some instances, adopted legislation. In 2016, 2 years ago, we enacted the Comprehensive Addiction and Recovery Act, a law that included a wide array of provisions advanced by many of our committees. The provisions in the jurisdiction of this committee included a number of worthy initiatives, such as pro-

grams to expand treatment as an alternative to incarceration. It is impossible not to see the contrasts without Congress' response to the opioid crisis in comparison to their responses to some other drugs, particularly crack cocaine.

While I agree that we should develop and implement the comprehensive strategy with respect to opioids, with the emphasis being on preventing and treating abuse, we did not take this approach with crack cocaine. There, focusing our response on the enactment of lengthy, mandatory minimum sentences, and treating the use of crack as a law enforcement issue.

That approach was wrong and continues to be wrong, disparately impacting African-American communities while fueling mass incarceration. We must not make that same mistake with any of the drugs classified as opioids, and we must reverse and rectify the mistakes we have made in other drugs such as crack, through an increased emphasis on prevention and treatment and by changing our counterproductive and unjust sentencing laws.

Certain opioids, such as heroin and fentanyl, are already subject to mandatory minimum penalties, and these penalties have not prevented the current crisis, and increasing them would also not be effective. We also do not need more "get tough" rhetoric from President Trump or Attorney General Sessions about imposing the death penalty for drug crimes, and we should not be telling prosecutors to ratchet up criminal charges and penalties for drug offenders. None of that solves the problem. Instead of doubling down on failed policies that do nothing more than proliferate misery, we need real leadership, involving a commitment to increase resources for alternatives that we know are actually effective.

There are a number of proven alternatives that are being implemented in the States, and we must commit to supporting them. For instance, law enforcement assisted diversion programs, known as LEAD, allow law enforcement to divert appropriate arrestees from criminal court, instead providing treatment and other services that address addiction and reduce recidivism.

Developed and initially implemented in Seattle, the LEAD approach is now being used with success in other areas. We should support efforts such as LEAD, as well as other approaches at the local level, including medication-assisted treatment, supervised injection facilities, expanding the availability of overdose reversal drugs, and better education of doctors and the public about the proper prescription and use of opioids as pain medication.

We will not be able to arrest and incarcerate our way out of a drug abuse problem that has many causes. Instead, we must support the development and implementation of a variety of solutions. I hope this will be the path of the committee as we consider our contribution to addressing this crisis. I yield back the balance of my time.

Chairman GOODLATTE. Thank you, Mr. Nadler. Without objection, all other opening statements will be made a part of the record.

We welcome our distinguished witness on our first panel. And, Mr. Patterson, if you would please rise, I will begin by swearing you in.

Do you swear that the testimony that you are about to give shall be the truth, the whole truth, and nothing but the truth, so help you God? Thank you very much. Let the record show the witness answered in the affirmative.

Mr. Rob Patterson is the acting administrator of the U.S. Drug Enforcement Administration. He is the principal advisor to the Attorney General on international drug control policy and related operations in the United States.

Mr. Patterson, welcome. Your entire statement will be entered into the record in its entirety, and we ask that you summarize your testimony in 5 minutes. There is a timing light on the table that will indicate when 4 of those 5 minutes have gone, and then, when it turns to red, your 5 minutes are up. We thank you for indulging us, and Mr. Patterson, you may begin. Thank you.

**STATEMENT OF ROBERT PATTERSON, ACTING
ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION**

Mr. PATTERSON. Thank you, sir. Chairman Goodlatte, Ranking Member Nadler, and distinguished members of this committee: thank you for holding this hearing on the opioid crisis. Our Nation has been devastated by opioid abuse, an epidemic fueled in part, and for a significant period of time, by a change in prescribing practices. This has helped create a generation of opioid abusers presently estimated at more than 3 million Americans.

Effectively combating this crisis requires addressing it from multiple angles: enforcement, education, and treatment. DEA's enforcement strategy utilizes a full spectrum of criminal, civil, and administrative tools to attack the trafficking of illicit and the diversion of licit supply.

We know that most new heroin users continue to begin their cycle of addiction with prescription pills, so we are constantly evaluating ways to ensure that our more than 1.7 million registrants comply with the law. Leveraging traditional enforcement methods with diversion authorities, DEA has established 77 tactical diversion squads and two mobile teams solely dedicated to investigating and dismantling criminal diversion schemes. In curbing diversion, we continue to integrate and strengthen our intelligence and enforcement efforts.

For example, in January, we analyzed DEA data alongside HHS and some State PMP data to identify prescribers and pharmacies whose activities warranted investigation. This analysis identified more than 400 leads, which were then provided to our 22 field divisions.

The resulting surge led to 188 active investigations, 28 arrests, 283 administrative actions, and removing the ability of 147 registrants to handle controlled substances. The complex nature of the epidemic requires data sharing and deconfliction, and fully committed to doing this better across the board.

Over the last 6 months, DEA has developed information sharing agreements with our State counterparts to share ARCOS data. Likewise, we need all States to find paths forward to share their PMP data, a vital piece of this puzzle.

Through a number of efforts we will discuss today, combined with an increased public awareness of the opioid epidemic, DEA

has seen a corresponding decrease in prescriptions for opioids. While this is a very positive step, we still face many challenges. As an example of these ongoing efforts, we continue to review proposed changes to our quota program with a goal of utilizing multiple data sets thoughtfully to assess production needs while avoiding shortages for patients.

We are, however, seeing a dramatic and disturbing shift from licit opioids to the illicit market. Criminal organizations have filled this void by producing and distributing cheap powder heroin, often mixed with illicit fentanyl and related substances, and then selling it in powdered form or pressed into counterfeit pills resembling licit pharmaceuticals.

The changing chemical composition of synthetics makes it difficult to intercept these deadly substances before they hit our streets, and prosecutions are hindered by labor-intensive court proceedings. For example, to meet standards set forth in the Federal Analogue Act, prosecutors must prove in each case a substance substantially similar in chemical structure and pharmacological effect to a schedule I or schedule II substance.

DEA has moved aggressively to place temporary schedule I controls on new and emerging synthetic drugs, including 17 fentanyl analogues. Unfortunately, the temporary emergency scheduling process of a substance is reactive, requiring us to first observe the deadly consequences of synthetic drug abuse before initiating control.

In February, DEA proactively placed temporary emergency controls on the entire class of fentanyl-related substances, in the attempt to help curb fentanyl-related overdose deaths. This is an aggressive step to combat an unprecedented threat.

The logistics of how this poison reaches the U.S. is yet another challenge. Movement of fentanyl varies from the direct mailing of small amounts to cartels moving bulk quantities through their already-established transportation networks.

Complicating the issue, especially on the direct mailing, is technology that allows sellers and purchasers to conduct seemingly endless and relatively anonymous transactions on the web. However, with agencies working together, FBI, U.S. Postal, HSI, CBP, and others, and our critical international partners, no issue is insurmountable. The seizure of the dark web marketplace AlphaBay and subsequent darknet cases are prime examples demonstrating that no criminal network is untouchable.

While DEA's top priority is enforcement, there is also a natural fit for us in education. We have partnered with leaders in prevention and education to provide direct outreach to young people and parents on the dangers of prescription and illicit drugs. Simultaneously, DEA has worked to improve communication and cooperation with the registrant community, offering year-round free training to doctors, pharmacists, distributors, importers, and manufacturers. Ultimately, to fundamentally change this epidemic, we must decrease demand for these substances, working collaboratively on all fronts.

I am extremely appreciative of your commitment and support to tackling this epidemic. DEA has reviewed more than 60 pieces of pending legislation and appreciates the opportunity to provide tech-

nical assistance wherever appropriate. Thank you for the invitation to be here before you, and I look forward to your questions.

Chairman GOODLATTE. Thank you, Mr. Patterson. We will now proceed under the 5-minute rule with questions, and I will begin by recognizing myself.

Mr. Patterson, I have been watching with interest the investigation currently ongoing at the Energy and Commerce Committee about the distribution of opioids to West Virginia. As you may know, my district is just across the border, and I have no doubt that some of the opioids from pill mills in West Virginia have ended up on my side of the border. Earlier this year, you testified about some of the DEA's historical failures to identify and stop these pill mills. What did the DEA learn from these failures, and what are you doing differently today as a result?

Mr. PATTERSON. Sir, I appreciate that question, mainly because, as we talk about the period of 2006 through 2010, which is where a lot of those events really started and blossomed in West Virginia, we and others did not do a great job with the data that we had. Part of that was how we got the data, and part of that was our responses to certain things that we saw, right. There was not a real-time look on these things. The compliance with the industry was also problematic.

I think the huge difference that we see now is that we understand more than ever, especially working with the States, how to use the various data sets that we have. And as I just explained, you know, the HHS data that we are able to obtain—DEA's ARCOS data, the State PMP programs, where they are participating with us—all essentially allow us to see the outliers. The key piece to us doing enforcement actions and trying to hold distributors and others accountable really comes from us being able to find where those pills ultimately end up on the streets. The key to that is that PMP data set, and when we move back from that.

So, we have got a ton of lessons learned. I know both you and Mr. Nadler started this way, and I think we are all growing and expanding from what works as opposed to what has not worked in the past, and important lessons learned.

Chairman GOODLATTE. Thank you. In a recent press release, the Department of Justice highlighted the DEA's continued efforts to reduce drug quota, the ability of approved manufacturers to make certain quantities of controlled substances, including powerful ones like opioids.

Could you please explain the proposed rule, and how this will help with preventing diversion? And, also, give us some assurance that when drugs that are used as means of getting people off of, other drugs like methadone and so on, to make sure that supply is still available to those who are prescribing it for people who are trying to overcome their addiction.

Mr. PATTERSON. No, I understand. And thanks, again, for that question, sir. So, quota is a delicate balance. The reality is that DEA, for a long time, essentially bumped quota up to ensure that there would be full access for manufacturers to produce X amount of product.

In hindsight, looking back on how we dealt with quota, the more you allow manufacturers to produce, it is a business. They have

more incentive to sell additional, which then drives more usage. So, what we have done over the last handful of years is to try and pull slack space out of that, for lack of a better word.

And now, the proposals that we put forward and that we are making are out there, and we just got comments back on, to take a look at other factors as we develop quota. And this is more on the prescribing side, as to the medical-assisted treatment side, but it has to deal with us taking in additional data sets, how we look at that, understanding the diversion in what we see.

And, quite frankly, I give credit to a lot of the States who have enacted legislation, and prescribers that have changed their methodology of a 5-day or a 7-day supply up front, which, all is pulling down how much pharmaceutical needs to be made. DEA has to be aggressive with essentially making sure that number is where it needs to be, with a heavy emphasis, though, on making sure that patients that need access to medicine have that access.

Chairman GOODLATTE. In your written testimony, you state that DEA is witnessing the transition from controlled prescription drugs to heroin and fentanyl and related synthetic analogues. What efforts is the DEA making to address this fundamental shift?

Mr. PATTERSON. So, I think, look, this trend has changed over the last couple of years, and we are trying to be much more aggressive on where our problem set really is. Fentanyl accounted for approximately a third of our overdose deaths, so the transition has really happened. As we see again, the licit market, or the pharmaceutical market, continues to come down. It creates a natural void where these criminal organizations will fill that void with their product for people that are truly addicted. And that is the struggle that we have.

Fentanyl, like I said, comes, essentially, to the United States in two forms: one is through smaller, much higher-percentage purity packages coming out of China, and then what we see coming across our southern border with the traditional organizations that have shipped heroin and methamphetamine and other drugs into this country for years, much lower concentration, although the volume is much higher. These are struggles that we are dealing with. The good piece of this is that all of your law enforcement agencies in this country are centering their efforts on the illicit market as we see this continuing to be the problem set moving forward.

Chairman GOODLATTE. Thank you. The chair recognizes Mr. Nadler for 5 minutes.

Mr. NADLER. Thank you. Mr. Patterson, in February of this year, the Department of Justice announced it would emergency schedule all illicit fentanyl. In its public announcement, the Department of Justice noted that this emergency scheduling action would mean that, "Federal agents and prosecutors can take swift and necessary action."

The Department of Justice has highlighted difficulty with prosecuting individuals for offenses under existing analogue control laws involving a suspected analogue of a controlled substance. Has this emergency scheduling action by the department facilitated the prosecution of individuals with suspected analogues of a controlled substance?

Mr. PATTERSON. Specific to fentanyl, sir? Specific to fentanyl, yes. So, the key for this, and I think this is where the struggle sits, is this is an aggressive use of scheduling on the fentanyl class.

And, again, when we talk about the balancing, HHS and others, you know, and their desire to do research and find actual medicines out of these medicines, when before we took the scheduling action, we went in and sought to see if anybody was looking at any of these classes of fentanyl that already existed.

Remember, this scheduled fentanyl that had not even come onto the market yet, as well. But, to look to see if anybody was trying to do research, and that answer was no, to the best of their ability to do that search. In addition, since we scheduled it in February, I am unaware and I have not been told by anybody about the efforts to do research in that class.

Mr. NADLER. Sorry, so, you are saying you are unaware?

Mr. PATTERSON. Unaware, sir.

Mr. NADLER. Of research?

Mr. PATTERSON. Of anybody asking to do research on the existing class of fentanyl that we see. The key to this really comes down to, sir, is the ability to charge criminal organizations that are importing the fentanyl as a substance. Using the Analogue Act, it is difficult, right? It is a time-consuming process for prosecutors and the reality is that this was the only way we could try and balance that out. And, again, balance being the key word here.

Mr. NADLER. Okay. Now, do you think that drug manufacturers should have more of a role in ensuring compliance with the Controlled Substance Act?

Mr. PATTERSON. Should drug manufacturers?

Mr. NADLER. Yes.

Mr. PATTERSON. Have more control.

Mr. NADLER. Have more of a role in ensuring compliance.

Mr. PATTERSON. Absolutely. I mean, one of the frustrations, I think, with the manufacturing population, so manufacturing and distributing somewhat lumped together, they are aware of the problems. They have been aware of the problems.

Frankly, we have done a lot of civil fines, but when you look at major businesses, civil fines seem to have little impact. And I think that is part of the frustration. In cases where we have not seen this behavior yet fixed, and we are talking about behavior that we have seen for the last decade, I think we have to hold them more accountable.

And that is why DEA, I think, is also taking a posture of, "Make sure that they are best informed." We have to work with them, which sometimes feels a little bit contradictory to do, as you are also investigating them. But we have to work to make sure that they understand their role in this place.

Mr. NADLER. And what is the total budget for the DEA for the current fiscal year?

Mr. PATTERSON. 2018 was just under \$2.2 billion.

Mr. NADLER. Just under 2.2?

Mr. PATTERSON. Yes, sir.

Mr. NADLER. And how much Federal money is allocated for drug treatment this year?

Mr. PATTERSON. I actually do not know, ultimately. I know that at one point, though, there were conversations. I do not know what is allocated, sir. I know there were conversations about, I believe, \$6 billion.

Mr. NADLER. All right, six. Okay. Now, in the past, you have stated that prescription monitoring programs, which involve State-to-State data sharing and mandatory prescriber registration, are important to helping create a clear image of where opioids are being distributed to the population. Can you discuss further the benefits of States participating in PMPs?

Mr. PATTERSON. So, I think that vast majority of States, and as we have gone and talked to people, I think doctors feel the same way, want to be able to do right in this space and be able to see what their patients are doing and what pharmacists are doing and prescribing, or what is going out. I should say, ultimately, to the user population, right, or the patients, in this case.

I think the key to it is where States either do not have the ability to connect with each other, or the systems actually are not being used, is highly problematic. So, you know, as I talked about in the opening, ARCOS is a critical first step for us to be able to take a look at where pills are going in, and we should take a look at that to understand where they are going into pharmacies. The key piece, frankly, is where you are seeing that diversion happening from the pharmacy area and from doctors, in some cases, out into the general public.

Mr. NADLER. Okay. I have one more quick question, thank you. Since 2011, the number of immediate suspension orders, which allow the DEA to free suspicious shipments of controlled substances when there is an imminent danger to public health or safety has significantly declined. Can you explain why this has happened in the midst of the opioid epidemic?

Mr. PATTERSON. Yes, sir. I would be happy to do so. So, there is two factors on this, and as I have gone around and spoken to a number of the members, one is that tool is an aggressive use of the tool against distributors. It is not a tool that was generally used against distributors. The case of using that only had happened a handful of times in the previous number of years prior to 2011, 2012.

The other piece of it is when the bill did change, the Ensuring Patient Access bill changed, it raised that standard to where the conduct would have to be much more egregious for us to be able to prove at the distributor level.

I understand, in talking to a number of folks, you know, again, through the various members, that there was confusion in the industry. And I think the importance here is to strike a healthy balance of making sure the industry understands exactly where the rule is in giving us a tool back that we can then use to essentially work forward.

Mr. NADLER. Thank you.

Chairman GOODLATTE. The chair recognizes the gentleman from Wisconsin, Mr. Sensenbrenner, for 5 minutes.

Mr. SENSENBRENNER. Thank you, Mr. Chairman. We have heard an awful lot about fentanyl analogues in the two previous series of

questions. I have a bill in to schedule fentanyl analogues. Does the DEA support this legislation?

Mr. PATTERSON. So, let me do it this way to keep myself out of trouble, which is: we have emergency scheduled the entire class of fentanyl analogues, and we need a legislative fix to keep this and have this remaining in schedule I.

Mr. SENSENBRENNER. How long does the emergency schedule last?

Mr. PATTERSON. So, it started in February. It will go for 2 years, and we can extend that for 1 year.

Mr. SENSENBRENNER. So, at the end of 3 years from February—which puts us at February 2021—you cannot do anymore without legislation?

Mr. PATTERSON. That is correct, and we will be back to the same problem of having to do one at a time and go through a decision.

Mr. SENSENBRENNER. Is it hard for a prosecutor to obtain a conviction based on an emergency schedule, rather than having this schedule done by legislation?

Mr. PATTERSON. I think it poses risks, as we get closer and closer to that 2021 date with how prosecutors would charge their cases. Because, in theory, they would have to charge both under the Analogue Act, as well as using fentanyl as a schedule I, because the balance would then come in to: if they charge a case and it has not gone to trial, my understanding is that, come February of 2021, that fentanyl drops off or we have not yet been able to do our emergency scheduling, it would be unscheduled. So, the answer is yes, it does pose challenges.

Mr. SENSENBRENNER. All right. I hope we can get this bill passed this year, because I think there is an urgency, rather than having to start over after the election of the next Congress. And I yield back the balance of my time.

Mr. PATTERSON. And if I could just add one other thing, sir. We look forward to providing any technical assistance on that, because it does require a legislative fix.

Mr. SENSENBRENNER. Thank you.

Mr. PATTERSON. Thank you.

Chairman GOODLATTE. The chair recognizes the gentlewoman from California, Ms. Lofgren, for 5 minutes.

Ms. LOFGREN. Thank you, Mr. Chairman. I was very interested in your testimony starting on page two. And I think trying to understand what is going on here in our communities is important to coming up with the proper solution.

You say that in 2016, almost 3.4 million Americans aged 12 or older reported misusing prescription pain relievers in the last month. And that prescription misuse is more common than use of any category of illicit drug, absent marijuana, which has now been legalized in half the States for one purpose or another. And that 75 percent reported non-medical use of prescription opioids before initiating heroin use.

Now, you go on to say that the reasons an individual may shift from one opioid to another will vary, but it is less expensive than the prescriptions. So, I am getting a picture, not just from you but from other witnesses at other hearings, that most people do not just start using heroin. For one reason or another, often times they

are prescribed or over-prescribed for some remedy an opioid, and they get hooked. And then they go on to use and overuse, and then when they cannot get the opioids, to go to the illegal provisions. Is that your understanding? Or, if I am wrong, correct me.

Mr. PATTERSON. No, I think that is a completely accurate understanding. And if I could add, you know, it always feels odd, but for me to be efficient in our law enforcement efforts, we have to understand the back-end problem of this, which is treatment, and what these people, or addicts, go through.

Ms. LOFGREN. Oh, absolutely.

Mr. PATTERSON. Frankly, when we go out and speak with them and understand their problems, I hear the same story over and over again, which is at some point, this opioid high that you get from it, and sometimes it is very quickly, becomes an issue of not being sick. And that is what then drives the switch from licit opioids, which they, you know, run into a problem of not being able to afford, and then, into the world of heroin.

In 2011, 4 out of 5 people started, prior to heroin, by misusing opioids. That number dropped down, I think, in 2016, to 3 out of 5, but that is still a stunning number, that 60 percent of your people started with a licit pill.

Ms. LOFGREN. Well, you know, if that is the case, it seems to me one of the most effective things we could do would be to focus on why people are using so much prescriptions. I mean, if you compare the use. You know, I am not one who says the cancer victim, you know, should die in agony. You know, that is not really what we are talking about.

But we had a witness in an immigration subcommittee hearing a few months ago who said that some of these companies were providing so much opioids, it would be enough for, you know, 10 pills for every adult in the town that was sent to the pharmacy. Obviously, someone must know that that is not a proper use.

And so, the question is, "What are we doing about that?" We have got companies that should know—they must know—that what they are developing is fueling this opioid crisis, and they are doing it anyhow, to make money. What is our strategy on that?

Mr. PATTERSON. So, again, I think this gets back to the education of Americans. The companies are not going to change their behavior.

Ms. LOFGREN. Well, let me interrupt if I may, because I believe in the education of Americans. I think people, you know, who break a leg, can say, "I do not want 50 opioid pills, you know, I want two." You know, but that does not get to the root of the problem, which is you have got people profiting, companies—real companies, not drug dealers—incorporated companies profiting out of starting this addiction. What is our strategy to go after that?

Mr. PATTERSON. So, the strategy, again, is to work with industry, and try and make them understand their role, whether they change their practice or not. But I will give you another fact that you can add to that toolbox of the argument of overprescribing. So, DEA has done these take back events for the last, you know, number of years. In total, it has been just about 10 million pounds we have taken back. So, in April, we took back—

Ms. LOFGREN. If I may interrupt? I do not mean to be rude, but we only have 5 minutes, and I have got 10 seconds left. I will just say that I am for educating people, I am for buybacks, but to allow certain companies to profiteer by addicting wide swaths of the country, and our action is, "We are going to work with them," I think that is insufficient. That is lame.

And I do not blame you; you are administering the law, but we need a very different strategy than we appear to have now. And I know my time is up, Mr. Chairman, so I yield back, and I thank you, Mr. Patterson, for being here.

Mr. PATTERSON. Could I just finish one thing real quick, sir?

Chairman GOODLATTE. Yes.

Mr. PATTERSON. So, I agree with you, ma'am. It has to start there. My point on bringing back the take back: every 6 months, we take in about 1 million pounds of pharmaceutical drugs. That is a conversation that has to be had. If we are returning that every 6 months, what are we doing wrong?

Ms. LOFGREN. Thank you, sir.

Chairman GOODLATTE. The chair recognizes the gentleman from Pennsylvania, Mr. Marino, for 5 minutes.

Mr. MARINO. Administrator, I have never worked with a finer agency than the DEA, and I see the positive move under your leadership.

In October 2017, the Washington Post and 60 Minutes put out a joint report on the Ensuring Patient Access and Effective Drug Enforcement Act, a bill which I was the House sponsor, because I heard from seniors and pharmacists in my district that they were not able to get prescriptions, especially for terminally ill patients.

This report was filled with falsehoods that completely misrepresented the law and its effects. After my legislation passed the House by unanimous vote, the Senate introduced their version of the bill, where my language of "foreseeable risk" was changed to "substantial likelihood," which is a much higher burden for the DEA to satisfy.

But this was language the DEA had asked for, and in Senate Judiciary hearing last year, when asked about the language, Ms. Demetra Ashley stated that the DEA supported the legislation and the version that passed. The bill then passed the Senate by unanimous consent, passed the House, again, by unanimous consent, was signed into law by President Obama at the recommendation of DOJ and DEA.

The DEA has now testified twice that the bill has in no way stopped the DEA from doing its job. In October 25, 2017 energy and commerce hearing, Mr. Neil Doherty, the deputy assistant administrator of the Office of Diversion Control testified, in court, it did not stop the DEA from doing its job in the diversion space.

In December 12, 2017 Senate Judiciary hearing, Ms. Demetra Ashley, the acting assistant administrator in the Office of Diversion Control stated that, "I agree wholeheartedly that it did not stop us from doing our job." She later stated, "Has it impacted our ability to issue ISOs? No, sir, it has not."

Since 2012, the DEA did not issue an Immediate Suspension Order, or ISO, against a drug distributor until 4 days ago, using the new "substantial likelihood" standard. Ensuring Patient Access

and Effective Drug Treatment Act was signed into law in 2016. So, for 4 years, the DEA did not issue an ISO under the prior standard. Taking all this into account, it would appear that the DEA shifted to using other tools to go after the opioid epidemic, rather than using ISOs against manufacturers, that the law did not hamper or stop the DEA from doing their job in any way, and that, very recently, the DEA used ISOs against a manufacturer, effectively showing that this language does not stop you from using an ISO.

The DEA now says they want to change the law and would like to see the “substantial likelihood” that the Senate passed, at the request of the White House, language to “probable cause.” My language that was in the original bill and passed in the House was “foreseeable,” which is a lower standard than either “probably cause,” and much lower than “substantial likelihood.”

I understand that the DEA is still advocating for probable cause, but I would be willing to consider a lower standard that would give DEA an even more flexible use of what you are currently asking for.

As I mentioned, my original language that passed the House was “foreseeable risk,” which is the lower standard. During the Senate Judiciary Committee hearing, Senator Blumenthal asked, “But you had to show some likelihood before?” and this was Ms. Ashley, the assistant administrator.

Her response was, “We were aiming to prevent diversion because it is foreseeable. If drugs are diverting, they get to someone who should not have them. It is foreseeable that there will be harm.” From reading that, it certainly seems that the DEA was also using a foreseeable standard before, in regards to the ISOs. That is the standard that was in my legislation.

I want to explain something here as far as “foreseeable.” The courts have ruled an act must be sufficiently likely before it may be foreseeable, in the legal sense. That does not mean simply imaginable or conceivable. Now, I am going to switch to probable cause.

What the Supreme Court says were, “the facts and circumstances within the officers’ knowledge, and of which they have reasonable trustworthy information, are sufficient in themselves to warrant a belief by a man reasonably cautioned that a crime is being committed.” That definitely is a higher standard. Would you agree with me, sir, that “foreseeable” is a lower risk than “substantial,” “probable” cause, and that is the lowest hurdle that you would have to get over?

Mr. PATTERSON. So, “foreseeable” is certainly lower than “probable” cause, and as I have discussed with you and others, I appreciate the ability to get that level as low as possible. The reason why we have picked “probable cause” is it is a well-defined, essentially, standard for our agency. As we looked at all of these issues, we found that we could meet probable cause every time. So, I appreciate your effort to go to “foreseeable.” At the same time, I think that using “probable cause” strikes a balance between the industry and understanding where that is.

Mr. MARINO. And I will support that, if that is what the agency wants. With that, I have run out of time. Mr. Chairman, could I enter some things into the record?

Chairman GOODLATTE. What do you have?

Mr. MARINO. I ask unanimous consent, I would like to place in the record the transcript from the House Energy and Commerce hearing on Wednesday, October 25, 2017, as well as the transcript from the Senate Judiciary Committee hearing on December 12, 2017 and December 17, 2017, a 60-minute transcript of David Schiller, a former DEA supervisor who said, "With the opioid epidemic getting worse year by year, special agent Schiller and his team wanted to send a message to the pharmaceutical industry. They wanted to fine the company a billion dollars to revoke registration distribution."

On to say that he was asked, "Did the DEA attorney actually tell you that they were not going to pursue that case because they had lawyers who went to Harvard and Yale?" Schiller said, "they told me those exact words because the case would take too much time and too much effort, by the way, and what if we lost," and this was a statement that came from the DEA and the Department of Justice back in 2014.

Chairman GOODLATTE. Without objection, they will be made a part of the record.

The chair recognizes the gentleman from Tennessee, Mr. Cohen, for 5 minutes.

Mr. COHEN. Thank you, sir. Mr. PATTERSON, first, welcome. The DEA has always been a position, I think, of great importance, and it is important that the DEA administrator stay current with what the people have shown, by their actions and their statements, what they believe is the right priorities for DEA.

And it has been pretty clear, as Ms. Lofgren mentioned, that 29 or 30 jurisdictions, in some way or another, have legalized marijuana for one purpose or another. And yet, because of the inaction of the DEA, marijuana is still a schedule I drug, along with heroin and ecstasy and acid. Do you believe that marijuana should be classified as the same as LSD, ecstasy, and heroin?

Mr. PATTERSON. So, the reason why it remains in schedule I is because of the science.

Mr. COHEN. The science?

Mr. PATTERSON. The science. So, FDA does its eight-factor analysis, DEA does its review, and therefore, it remains in schedule I.

Mr. COHEN. Before we talk about the science, and I am happy to hear that you believe in science, that is refreshing. What do you think? Do you think marijuana should be schedule I? Based on your knowledge of the harm that marijuana causes, as distinguished from the harm that heroin causes the public and society?

Mr. PATTERSON. So, I am going to give you my honest opinion. And this actually does not shape how we do enforcement at DEA, because our priorities are the biggest priorities that we face, which is the opioid issue, methamphetamine, cocaine is now on the resurgence.

So, marijuana, obviously, is lower on the scale of what we do. And where we look to deal with that is in States where we see the importation of crime into those States from other States that are growing to distribute it back out, or exportation from those States, groups that are violent, other actions that are going on. So, that is where DEA prioritizes.

I fear—and I am just giving you my honest opinion—that we are going down a bad path with marijuana. And I will tell you the reason why I say that. This is not from, necessarily, the law enforcement person, because if I give you the law enforcement version, it is discounted as law enforcement. All of the driving conversations of this generally go around revenue. And that is unfortunate to me.

And I think 10 years ago we would sit here, and we could have this debate as to what is better, what is worse, you know? Is heroin worse than marijuana? And I am not going to debate that because I think, to me, they are two completely different things. Right?

I think the concern we see is we now have a body of evidence in States that have run what I call “the social experiment” for 10 years. Right? So, Colorado is a great one. And if we have an honest conversation about what we are starting to see in Colorado, my fear is that in 10 years, and I will not be sitting here, but you will all have someone here from DEA or some other agency saying, “Why was no one saying something?” I see that path coming.

And frankly, if you look back 20 years ago on the pharmaceutical world, people were screaming into the wind. It was a small percentage of people really concerned about what they were seeing. You have extremely high THC and, putting all the other things aside, right, property values in Colorado, or the fact that revenue is not essentially making up for what the costs are, issues with children, all these other things.

If you take that all and just put it aside, and simply ask the question to the adults in this country, which is, “At what point did we determine that revenue was more important than our kids?”

Mr. COHEN. Mr. Patterson, I appreciate your statements, and I can see where you have a different perspective than some previous DEA administrators, at least your honesty. Because I think the last one under Obama, I think, thought like you did but did not talk like you did.

I think most adults do not see it as dollars and cents. Most adults see it as a freedom issue and taking somebody’s liberty from them for smoking marijuana.

And the fact that three and a half times more African-Americans than Caucasians are arrested and lose their liberty, and possibly their hope in the future, for educational Pell Grants or education scholarships or public housing if they need it, is taken away from them because of smoking a plant that is legal and that does not cause people to die. I look at it, most adults look at it as a freedom issue and, as you put it as beneath three other drugs, I think. And I am sure you put meth above it, as well.

Mr. PATTERSON. Probably farther down than that.

Mr. COHEN. Yeah. And I mean, meth kills people. Crack can kill people. You get addicted. Opioids, you get addicted, and heroin, you die, kill people. Marijuana is not the same thing. So, there is a limited amount of resources the DEA has, police officers have, judicial law enforcement, everybody, and there is an opportunity cost. And when you spend time dealing with marijuana, all you are doing is taking time away from drugs that kill people and cause crimes.

Mr. SENSENBRENNER [presiding]. The gentleman’s time has expired.

Mr. COHEN. So, I thank you for your honesty and appreciate the time, and you can answer some more, if you would like.

Mr. PATTERSON. If I could just add one comment on the end. So, DEA does not expend its resources on users of marijuana. And quite frankly, I am not sure what State is. So, I think that you see, even States where it remains illegal, I do not see a huge enforcement presence. That is a good conversation to have, but I hear this statistic all the time, that there is mass incarceration of users, not just of marijuana but of drugs in general, and I do not see it. So, it would be a conversation I would like to have further, to be honest with you.

Mr. COHEN. Thank you, sir.

Mr. SENSENBRENNER. The chair recognizes the gentleman from Florida, Mr. DeSantis.

Mr. DESANTIS. Thank you, Mr. Chairman. Good morning, Mr. Patterson. So, if you look at the opioid crisis, what is the driving force right now? Because I know that, you know, there is a history of the prescription medications and the addictive qualities of that. But I look at what is happening with the fentanyl and some of this stuff pouring into the country. This stuff is poison. It is very lethal. And it seems to me, prescriptions are down for some of the pain killers, and I know they are all important. But is it more being driven right now on the prescription side, or on the street drug side?

Mr. PATTERSON. No, I think, and we had started off by having that conversation, we have crossed the paths, of where the licit, or the prescription side, is now the leading problem. Fentanyl and heroin and other adulterants out there are our problem. And frankly, what drives this now is an abuser population of 3-plus million people that we have to work with, and that then comes hand in hand with treatment and other issues that we have to deal with there. But, as we have seen with every other illicit drug, there are cartels and groups that are willing to fill this space to meet that need.

And you know, we are here on an opioids conversation. We have a massive methamphetamine problem in this country, too, that most of your States are struggling with, that does not get a lot of conversation. But we have a drug abuse problem in this country, and it occupies the illicit space, and these organizations will continue.

Mr. DESANTIS. And that is being driven by organizations that are bringing it across the southern border, primarily?

Mr. PATTERSON. Certainly. Southern border and off into the areas of China and India.

Mr. DESANTIS. That is an interesting thing, because we did a bill, President signed it a couple months ago, to try to let the Post Office intercept some of this stuff that gets mailed in. If they try to mail it Federal Express, FedEx will stop it, but the Post Office just kind of comes in.

So, have you seen any change of the Post Office's ability to interdict some of the stuff that is being shipped from China in the last, you know, month or two, since this bill has been in effect?

Mr. PATTERSON. So, I do not know if it is specific to the bill, because I am not familiar with that bill, sir, but the U.S. Postal Serv-

ice has done an amazing amount of work with trying to get additional data to help them. We are trying to fuse that as a law enforcement body with all the data that we have.

So, in other words, where we see issues and problem spots coming up, so that they can be more nimble. But the reality is that you have a volume problem, when we talk about the logistics of packages coming in. So, that is not a southern border problem. The southern border problem is the roots that we have always dealt with, the Mexican cartels. Really, when you get into U.S. Postal's lane, that has to do more with the packages that are coming out of China and other places around the world, and that is a pure volume problem.

So, we have to be smarter, as an overall group, as to how we target and use those resources the best way. I do not know if we will ever get to a point where we will be able to scan through every piece of mail. And remember, you know, ounces, right? Not even ounces, right? You know, grams of fentanyl produce thousands of dosage units. And if you can think about that, that means that I am just putting, you know, a couple of grams, or a sugar pack, in an envelope, and asking U.S. Postal to find that as it comes in. It is highly problematic.

Mr. DESANTIS. Now, what is the typical profile? And I know these things vary. But, so, someone overdoses on fentanyl. Is this somebody who was starting to do prescription drugs and then ended up going to street drugs? Did they start with marijuana and then go? I mean, I am sure it varies, but just give me a sense of how it gets to the point where we have users of a very highly lethal, highly addictive product.

Mr. PATTERSON. Right. So, I think when you look at the overdose population, and there are probably better people than myself to speak to this. The unfortunate thing is it can be one of a host of things, right? So, you have your heroin user where it is adulterated with fentanyl. We are seeing it now in cocaine, as well. In fact, there was just a recent article that came out on all these cocaine users, that the ones that survived had no idea that there was fentanyl in the cocaine. That is also a disturbing trend we see. But you also have the people that go out and believe they are buying a licit pill, right, that is nothing more than binder and fentanyl. And I think this is the problem.

And as you listen to the stories, I stopped using the number of overdose deaths a long time ago. Because, to me, the individual stories are what is critical here. And they all have the same kind of feeling, right? "I did not understand that it was happening in my family," "did not understand the addiction of my loved one," but it happens in so many various ways, and that is part of the challenge that we have here.

Mr. DESANTIS. What can States do to help what the DEA is doing?

Mr. PATTERSON. So, look, again, the continued number to drive down is that population that is using or abusing opioids. And that still comes on the prescription side. So, I see States being very aggressive in that space.

I am happy that groups like ADA, the American Dental Association, has come out and talked about prescribing rates. We have to

fix that problem. And although it is a good trend down, we can not let that continue any other way than down. And we see a handful of States where it is either flat or still continuing to go up. That is where we are putting our efforts in on the prescription side.

On the illicit side, it is going to be essentially, again, an educational problem mixed with law enforcement.

Mr. DESANTIS. Thank you. My time is up.

Mr. SENSENBRENNER. The gentleman's time has expired. The gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Patterson, welcome. Thank you and your men and women for the work that you do. In particular, let me acknowledge the team you have in Houston, Texas, and the "bring your drugs in" or "bring your drugs back" day that you had all over the country, I believe, just a week or so ago, if I am clear on the one that we had here in Houston, or forthcoming. So, thank you for that kind of work.

Let me just remind you of the ways of different drugs from the crack cocaine, heroin, of course, fentanyl is something that this committee has addressed, and it is a sensitive issue when you begin to think of mandatory minimums and the impact. You all are the enforcers, but you know what happened with mandatory minimums. Sick people went to jail, if you will, or people that were using small amounts, and we do not know if it benefitted or not.

So, let me just ask you this question: with respect to people being incarcerated who are addicted or users and they were caught up, probably may have had a mandatory minimum, do you think it is on the recidivism side of it, because you see those individuals back in your cycle, that there should be a major component of drug treatment in the incarceration mode, in the prison system? That that should be an aspect for those individuals, as relates to recidivism?

Mr. PATTERSON. So, thank you for that question, and I go back to what I just said a few minutes ago. So, I think DEA predominately sees—and I should not even say predominately, I mean, we deal with the distribution end of this. I think a State and local approach is a very different feel, right? They are dealing with people that are generally impacted. And I am not saying that people that we want to arrest in the distribution stream also do not have substance abuse problems.

I think there is a host of programs out there where States are trying. I am probably not the right guy to speak to that. I think that I am certainly a person, though, that believes that people that are impacted by drug abuse need help.

And, you know, there are times and I have had conversations with, you know, first responders, EMS, State and local police, local prosecutors, in which, frankly, the arrest is saving certain peoples' lives. Right? Because it puts them down a path of treatment. But you have to want to be treated, as well. I think this is one of the delicate balances and I do not feel comfortable speaking for the States as they look at that, because we do not necessarily deal in that space, if that makes sense to you.

Ms. JACKSON LEE. No, it does make sense. We do have that problem in the Federal system, though. There are people in the system that are addicted. But I appreciate the thoughtful response.

Let me ask you, as relates to distributors: do you think there are adequate consequences? Or, well, let me just say this: under the Controlled Substances Act, the applicable regulations require the distributors to report orders of an unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency, to the DEA. Is that correct? Are they supposed to do that?

Mr. PATTERSON. That is correct. Suspicious activity reports.

Ms. JACKSON LEE. Thank you, and I like it in that context: suspicious activity. Do you think there are adequate consequences for distributors that fail to report orders of unusual size, orders that deviate from the norm, redundancy, and orders of unusual frequency?

Mr. PATTERSON. So, I do not believe that is happening as much as it should be in the distribution world. We are trying to make efforts at DEA to get additional information out there to help in this.

Ms. JACKSON LEE. But do you think there are consequences for those entities that are engaged who fail to report unusual size, and sales that deviate from the norm, and orders that are unusual frequency? Are the consequences strong enough?

Mr. PATTERSON. The consequences have traditionally been fines, civil fines. And you recognize that there are certain companies out there, certainly when you look at the bigger manufacturers, those fines have, unfortunately, become the price of doing business. There has to be more accountability in that space, but DEA also needs to do a better job in terms of how we look at those and hold people to that level of accountability.

Ms. JACKSON LEE. Let me ask you this final question: in the landscape of drug containment, or responding to the vast drug world, where are we in 2018? Staffing, with DEA, and as well, success.

Mr. PATTERSON. So, staffing is a challenge, has always been a challenge for us. The good news is that we have a healthy influx of State and local partners that come on to our task forces. We just announced recently that we got funding, and I appreciate the funding that we did get, to bring on an additional 400 State and local task force officers. That is our true quick force multiplier, is we try and ramp up. But staffing, I think, will always be a problem.

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

Ms. JACKSON LEE. Thank you very much. Thank you for your service.

Mr. SENSENBRENNER. The gentleman from Texas, Mr. Gohmert.

Mr. GOHMERT. Thank you, Mr. Chair, and we appreciate your being here, Mr. Patterson. It has been several years ago, but Steve Chabot and I had journeyed down to Colombia and met with DEA officials there and went out into the jungles, basically, and looked at all the efforts we had at trying to help Colombia combat cocaine. And it was a huge problem at that time, and the FARC's were pretty much running things when we were there. But it made a great deal of impact and seemed to dramatically cut the amount of coca that is raised and cocaine that is sent up.

We were told that two-thirds of the cocaine came up by fast boats on the Caribbean side, Gulf of Mexico side, and about a third went up to California. And then, they put in in Mexico—and I asked why

they did not just go ahead to the beach in Texas or California, and our eight DEA agents said it was because they are business people, and the odds of getting it across the Mexico-U.S. border were so much better than if they landed even on an abandoned beach.

Back then, we did not have drones that could be used, and my understanding, and I want to know if it is correct, is that we have dramatically impacted the amount of cocaine coming up from Colombia, is that correct?

Mr. PATTERSON. I think, for a period of time. I think with the peace process with the FARC—and this is a relatively long answer and I think you may have more that you want to talk about—I mean, I would be happy to come and sit down with you. There is a real issue with the production of cocaine in Colombia, yet again, that I think we have to wrestle with. We have had these conversations with the government of Colombia and our counterparts in the law enforcement world. There are a lot of challenges in this space, in what they were dealing with, with the FARC, but it is problematic, in terms of production, again.

Mr. GOHMERT. Is it still true that most of what they send north to United States goes across the water, puts into Mexico, and comes across our Mexico-U.S. border?

Mr. PATTERSON. Yeah. Central America into Mexico, Mexico up, or directly into Mexico. Correct.

Mr. GOHMERT. Yeah. Do they skip most of the Central American countries and just come in at Mexico?

Mr. PATTERSON. I think it depends on the organization, sir. So, I mean, regardless, it is coming across our southern border.

Mr. GOHMERT. Okay. Now, I know there has been great issue raised in recent years about the disparity in Federal penalties for possession for crack cocaine as opposed to powdered cocaine. And Dan Lungren that was here had pointed out that in the 1980s, most of the Republicans were following the lead of the Congressional Black Caucus members who were saying, like Charlie Rangel, that this crack cocaine is a scourge on the African-American community.

And if you are not willing to really come down with powerful punishments even more so for crack than for powder, then, you know, you are discriminating against the black community. And for that reason, people like Dan said, “We voted for it because that is what they said was best for the black community.” Obviously, since then, we have found there really should not be a disparity.

And I realize I have just got 1 minute, so let me just go directly to this question: we now have drones. How much help do you think you could use from drones? Have you made a specific request for a fleet of drones to help patrol both our Mexico-U.S. border and the Gulf of Mexico and Pacific?

Mr. PATTERSON. So, sir, we have not specifically.

Mr. GOHMERT. Do you not think they would help?

Mr. PATTERSON. I know that we work well with, obviously, CBP. So, I view it more as we would pass actionable intelligence to CBP to work on that particular issue on the border.

Mr. GOHMERT. You would not want a fleet of drones for DEA’s own use?

Mr. PATTERSON. That is a good question. I think, in terms of border security, we are going to leave that to CBP and others to work on that.

Mr. GOHMERT. Well, I understand, but you have got the Gulf of Mexico and you have got California.

Mr. PATTERSON. Right. It is something I would certainly think about and come back to you.

Mr. GOHMERT. We would encourage that. Thank you. I yield back.

Mr. SENSENBRENNER. The gentleman from Georgia, Mr. Johnson.

Mr. JOHNSON of Georgia. Thank you, Mr. Chairman. Sir, of the 64,000 drug overdose deaths in 2016, you are familiar with that figure, right? 64,000. What percentage of the 64,000 were for non-prescription opioids; in other words, heroin and fentanyl?

Mr. PATTERSON. So, fentanyl alone makes up for about 20,000, so roughly a third. And where heroin and fentanyl came, combined, I do not recall. Overall, "opioids" was 44,000 of that 64,000.

Mr. JOHNSON of Georgia. And, of the 64,000, how many deaths came as a result of overdosing on marijuana?

Mr. PATTERSON. I do not recall even seeing that on the chart.

Mr. JOHNSON of Georgia. So, in other words, you do not have any information that there is any death that marijuana is responsible for, within that 64,000?

Mr. PATTERSON. I am aware of a few deaths from marijuana.

Mr. JOHNSON of Georgia. You are aware of a few deaths from overdosing on marijuana?

Mr. PATTERSON. I do not recall if it was overdosing, but deaths attributed to the use of marijuana.

Mr. JOHNSON of Georgia. Deaths attributed, okay. What do you mean by that?

Mr. PATTERSON. I do not recall whether it had been adulterated with something else. I would be happy to go back and look.

Mr. JOHNSON of Georgia. I would love for you to do that.

Mr. PATTERSON. I understand the issue here, which is, one is not comparable to the other, I think is what you are asking me.

Mr. JOHNSON of Georgia. How many drug arrests throughout the country in 2016 for all illegal substances, drugs?

Mr. PATTERSON. I do not know.

Mr. JOHNSON of Georgia. According to a Washington Post article, which I just had here, which is dated September 26 of 2017 by Christopher Ingraham, he notes that more people were arrested last year over pot than for murder, rape, aggravated assault, and robbery combined. About 800,000 arrests for pot in 2016.

Now, you stated, in response to Mr. Cohen's question, you pretty much intimated that marijuana arrests were not that profound, not too many. But 800,000 is quite a big number, is it not?

Mr. PATTERSON. Again, I am referencing what I see in the space we work at.

Mr. JOHNSON of Georgia. And that is just for marijuana.

Mr. PATTERSON. Right. But again, the task forces that we participate with, DEA as a whole, these are certainly not our numbers and what we see.

Mr. JOHNSON of Georgia. Yeah. The ACLU did a study which determined that African-Americans are 3.73 times more likely than

whites to be arrested for marijuana. Do you agree or disagree with that number?

Mr. PATTERSON. I have no reason to dispute the number.

Mr. JOHNSON of Georgia. Do you believe that marijuana being listed under schedule I has anything to do with Federal, State, local law enforcement policy, with respect to those 800,000 arrests?

Mr. PATTERSON. Well, again, I would go back on the Federal policy. I just do not see those arrests happening in the Federal space, and I would not be the person to address State and local arrests.

Mr. JOHNSON of Georgia. Okay. I am going to yield the balance of my time to Mr. Cohen.

Mr. COHEN. Thank you, Mr. Johnson, I appreciate that. Mr. Patterson, you said the science had to be looked at, and it does, but I think the science has got to be faulty. The basis to list a drug in the schedule is likelihood of propensity to making someone addicted. Marijuana does not cause addiction, does not cause addiction.

And the second thing is uses that can be seen in medicine, for health, and there are lots of people, veterans in particular, who say that the pain relief that marijuana gives them is so much better than opioids, and it keeps them off opioids, that it also helps people with their appetites, et cetera, et cetera. So, the science is wrong, and I hope you could try to see a new scientific study that reflects the science that is real and that reflects today's values.

And as far as you said of Colorado, do you think marijuana is worse than alcohol for Colorado, as far as traffic deaths, domestic violence, assaults, murders?

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

Mr. COHEN. Can he respond?

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

Mr. COHEN. But the answer has not expired.

Mr. SENSENBRENNER. The gentleman's time has expired. Welcome to Rome. We will now hear from the gentleman from Colorado, Mr. Buck.

Mr. BUCK. Thank you, Mr. Chairman. If the witness would like to answer the last question, please feel free to do so.

Mr. PATTERSON. So, sir, to wrap up on your question, I do not like getting into the comparison of one being better than the other. I think we have a substance abuse problem in this country and to add to that is problematic.

Mr. BUCK. Good morning. First of all, thank you very much for meeting with me a few months ago. I am concerned about sanctuary city policies and their effect on the opioid crisis. When I was at the U.S. Attorney's Office in Denver, Denver was a hub city for heroin and cocaine and other serious drugs that were imported into the country, and from Denver, drugs were transported all the way to the Canadian line and Nebraska, Kansas, Utah. And I contacted some friends in law enforcement just recently, within the last couple of months, and they tell me that Denver is still a hub city for heroin in particular. Heroin is not grown in this country, am I correct?

Mr. PATTERSON. That is correct.

Mr. BUCK. And is it your opinion that Denver is still a hub city for the distribution of dangerous drugs like heroin?

Mr. PATTERSON. Yes, sir.

Mr. BUCK. And the importation of those drugs like heroin comes from other countries and then goes into Denver. And how does that transportation happen?

Mr. PATTERSON. You are talking about the routes that go into Denver? Predominately, I would say through vehicles, right? Trucks or smaller passenger vehicles.

Mr. BUCK. Okay. So, it typically comes across the southern border?

Mr. PATTERSON. Yes, sir.

Mr. BUCK. It may come in by sea, but typically comes across the southern border, and is transported by human beings in vehicles to a place like Denver.

Mr. PATTERSON. Right. When you are talking about the traditional cartels, that is correct.

Mr. BUCK. And typically, those individuals that are transporting the heroin are illegal immigrants. They are illegally in this country. Is that fair to say?

Mr. PATTERSON. I think that is a fair statement.

Mr. BUCK. Okay. So, a city like Denver, that gives sanctuary to illegal immigrants that are involved in the drug trade, is in fact aiding and abetting—or, I will let you use your words, but my words, “aiding and abetting”—the opioid epidemic that we have in the Rocky Mountain region.

Mr. PATTERSON. I think that where this really becomes problematic is the ability for State and locals to impact and work those types of cases. Obviously, on the Federal level we still can, but it impacts our partners in that fight. And as I just talked about before, the State and local population and how we worked those cases is a critical piece.

Mr. BUCK. You were former law enforcement, before you got a cushy desk job, as I might put it. You actually worked the streets. And you knew, and I am hearing this from narcotics officers with the Denver Police Department, and I say “cushy” with tongue in cheek, please.

Mr. PATTERSON. It does not feel that way most days.

Mr. BUCK. Especially now, I would guess. But they tell me that in a typical drug transaction, you have one person that accepts the money from the buyer. You have another person who delivers the drugs to the buyer. And you have one or two lookouts who are making sure that if they see anything suspicious with the police, they can signal the other two people.

So, in a drug transaction like that, with four individuals, you have two individuals that you can arrest and prosecute for the crime of distributing a dangerous drug. You have two other people that are very difficult to prosecute unless they actually get involved in the hand to hand in one way or another.

And so, typically, what would happen in that drug transaction is ICE would be called in, and the two individuals that were lookouts could be deported if they were in this country illegally, but maybe not prosecuted. And I will give you the remainder of my time here, but in that situation, is it important in the fight against the opioid crisis?

Is it important in the fight against heroin distribution for State and local officials to be able to work with the Federal Government to disrupt drug organizations, so that we are safer in our communities and we stop hub cities from spreading this poison throughout the region?

Mr. PATTERSON. Absolutely. It is not really a long answer, right? Our ability to work with those partners and the intelligence and evidence that they gather at the State and local level, is critical to how we do our job.

Mr. BUCK. And I guess my point is that it is not always prosecutable cases that disrupt organizations, right?

Mr. SENSENBRENNER. The gentleman's time has expired. The gentleman from Louisiana, Mr. Richmond.

Mr. RICHMOND. Thank you, Mr. Chairman, and thank you, Mr. Patterson for being here. I asked you a series of questions and you have been very kind today in answering, either in your professional opinion or your life experiences being a law enforcement officer. And I would like to just keep doing that, but just let us know when you are answering as DEA administrator and, too, from just your life experiences. But let me give you some stats first and ask if you have any reason to disagree.

At the height of the crack cocaine epidemic, you had maybe 2,500 deaths associated with crack cocaine, only in terms of the health aspect of it, not with the crime associated with it. Would you have any reason to disagree with that?

Mr. PATTERSON. No, I believe that is consistent with what I have read in the past.

Mr. RICHMOND. And I think what we heard today, overdose numbers are somewhere around 64,000 in the U.S.

Mr. PATTERSON. For all drugs, correct.

Mr. RICHMOND. Correct. And fentanyl and other opioids, I think, is somewhere around 20,000?

Mr. PATTERSON. Opioids, in total, is 44,000.

Mr. RICHMOND. And the other research shows that about 80 percent of the opioid deaths are white, 10 percent black, 8 percent Hispanic. Any reason to dispute that?

Mr. PATTERSON. Honestly, sir, I do not know the breakdown of what that is. I know it goes across all spectrum of people.

Mr. RICHMOND. And do you think that our addiction substance abuse treatment infrastructure in this country is adequate?

Mr. PATTERSON. No.

Mr. RICHMOND. Do you think that if we, in 1980, when we first had a drug epidemic, if we would have answered that with the substance abuse treatment model that we are trying to do now, that we would be ahead of the curve in terms of creating that substance abuse infrastructure, so that today we would not find ourselves in such an inadequate manner to treat the substance abuse we have in this country?

Mr. PATTERSON. So, I am going to give you my personal opinion here, which is, the infrastructure is important. I think, in dealing with the opioid issue, you have a much different issue than cocaine or crack cocaine, sir.

Mr. RICHMOND. Well, if you can briefly tell me the difference, I would love to hear it.

Mr. PATTERSON. So, the opioid path to recovery, in talking to treatment folks, is amazingly hard, and a long-standing problem that they are going to have to deal with for years to come. I think there is a more treatable solution when you talk about cocaine.

Mr. RICHMOND. Which actually stuns me because, if you are telling me it is a lot easier—well, you did not say a lot, but you said it was easy—to break the cocaine addiction, or at least treat the cocaine addiction. Then it would just make sense to me, instead of the path we took, which was mass incarceration, mandatory minimums, to take a health approach, which is what we are doing now in terms of the public health crisis, and treat the addiction as well as fight the violence and the distribution.

But we did not treat the addiction. And I just believe that, had we treated the addiction in the 1980s, we would actually have some addiction treatment infrastructure in this country that would help us become the framework for how we save all of these lives that we are losing today. Am I wrong for drawing that conclusion?

Mr. PATTERSON. I would not say you are wrong. I think, look, there is obviously an evolving process of all best practices as we move forward. And I think, look, hindsight is always, you know, a good thing to go back on. I do not dwell, necessarily, in the past, but we learn lessons every day. So, to your point, you know, look, if things had been different in the '80s, would they be different in 2018? It is very conceivable that the answer is yes.

Mr. RICHMOND. And I do not want to dwell on the past, but I think that we have to learn from the mistakes in the past, and part of our mistakes in the past, some of those people are still incarcerated today. And every dollar we spend on incarceration actually makes every neighborhood, every mother, every father, every grandmother less safe, because it is money that could go to something that would actually prevent a crime.

For example, we do not call opioid-addicted children “crack babies.” I mean, there is just a difference, and I will just close with this. I have 10 seconds left. But with the crack epidemic, when we found a grandson in public housing with cocaine, law enforcement pushed to evict the mother, we passed Federal law to do that.

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

Mr. RICHMOND. Are we doing that with opioids?

Mr. SENSENBRENNER. The gentlewoman from Georgia, Mrs. Handel.

Mrs. HANDEL. Thank you, Mr. Chairman, and thank you, Mr. Patterson, for being here. This has been very, very helpful. I wanted to touch on neonatal abstinence syndrome. As you can imagine, with the opioid crisis, we are seeing an increase in babies born with addiction. Yet, DEA does have a policy where it is maintenance only for an addicted mother, versus being able to move that mother off so that the baby is not born with that syndrome.

There has been some compelling research out of the Medical College of Georgia, Augusta University, looking at being able to do programs to move that mother off of addiction. That has significantly reduced the neonatal abstinence syndrome. Is that policy something that DEA is looking at to, perhaps based on some additional research, you might adjust?

Mr. PATTERSON. I would be happy to go back and go through the details with you on the policy and any implications it has. I mean, my exposure to this has been primarily in people I talk to in treatment more than anything else, in terms of the issues related to pregnancy and addiction, and the concerns, quite frankly, of bringing addicted people off during their pregnancy.

Mrs. HANDEL. Could I follow up with your office and share this new research with you? Maybe I could work with someone.

Mr. PATTERSON. Absolutely. I would be happy to read it, because, like I said, me being better educated helps us make better decisions in this space.

Mrs. HANDEL. Great. Wonderful. I wanted to also follow up; my colleague, Representative DeSantis was talking a little bit about fentanyl coming in from China. And I know that last month, the Justice Department arrested 55 indictments in international opioid and fentanyl trafficking rings. Can you just give us a sense of what degree of a dent, small, medium, large, that is even making? And just really the bigger picture about China and the influx of fentanyl.

Mr. PATTERSON. So, I think the critical thing to understand here is that our efforts with DEA and our other law enforcement counterparts in the United States, working with especially the Ministry of Public Security in China, kind of the DEA of China—we are learning more and more not only about the fentanyl itself but the precursors that are then going down into the South and Central America for not just this but methamphetamine and other drugs.

So, there is a good and healthy relationship in terms of how we are trying to work together, recognizing the challenges. The DEA is putting additional people in China, in Guangzhou and looking at some other places to try and leverage better where we can share information back and forth.

I think the key to this is, you know, we have a demand problem that is always going to continue to pull drugs, and so, as we work better with China, we are going to have to then deal with India or other places. So, you know, as you squeeze one part of the balloon it goes someplace else. Demand is a critical piece of this.

I would love to tell you that law enforcement, you know, this could sit at the feet of us, and we could get this fixed, but that is why I always go back to it is got to be a three-piece approach to this.

Mrs. HANDEL. And one last question. If right now, today, you could have two pieces of legislation, additional authority resources, two things that you could say to us in this room that if you had this today or tomorrow it would help you in your effort, what would that be?

Mr. PATTERSON. SITSA is one. The second is, as I stated off by starting with this, we have to deal with this fentanyl issue, so, whatever piece of legislation ultimately we come up with, we have to permanently schedule that in Class I.

Mrs. HANDEL. Great. Thank you very much. Mr. Chairman, I yield back.

Mr. PATTERSON. Thank you.

Mr. SENSENBRENNER. The gentlewoman's time has expired. The gentleman from California, Mr. Swalwell.

Mr. SWALWELL. Thank you, Chairman. Mr. Patterson, first, thank you and your agents for the work that they do in our communities, putting their lives in harm's way every day. It does mean a lot to me and my constituents. You have a presence in our district, and you have worked very closely with our local law enforcement, and I do appreciate that.

There are a number of different, I think, tracks to take to address opioids in America and what we can do to reduce addiction. And I also want to associate myself with Mr. Richmond and a lot of his concerns about just some of the issues and lessons that we should learn from the past. But I want to focus on teenagers.

I have met with families in my district who have lost a teenager, a high schooler, to opioid addiction, and, you know, for many of them, as you described earlier, they describe the same symptoms; they describe the same pattern of behavior. And then, oftentimes it is too late, and the loss, you know, is quite overwhelming to go back and fully understand what they could have done differently.

But what can we do differently with high schools, with the physicians and dentists to these young men and women? I fear that, you know, there is an over-prescription, particularly with young people who do not necessarily appreciate the effects, and then they are down a rabbit hole that they can never get out of. So, if you could first just talk about what we could do with the teenage population as far as awareness, you know, whether it is in the schools, local communities, or the physician community.

Mr. PATTERSON. I will say, I appreciate that. And so, DEA has a program called Operation Prevention which is in the schools, it was done in public-private partnership with Discovery Channel. The key to this, and I think to your point, is we have to start with education and not at high school. It has got to be before high school. I think we all recognize that kids that are now 10 or 11 are probably where we were maybe when we were in our early 20's.

I mean, they are bombarded with technology, they understand things in a much different way, and they have grown up much quicker than we did. So, the key is to get to that age. And I hate to do this, but I am going to do it to you, and this is what concerns me about marijuana. Right? Because those same stories I hear all the time, I generally hear marijuana introduced.

And again, I am not going to compare what is better, what is worse. I am not going to say it is a gateway; I am not—the problem is that these things all seem to dovetail together, and my concern is—and again, I will take my DEA hat off for a second—as a person in the United States, what message do we send as we try and navigate this space in terms of that? And I think that is problematic. So, the education of our youth is important.

Where it really seems to hurt, and more than anything else, is we have these pharmaceuticals that all sit in our house. And I recognize I am going to run you out of time here, and you probably have other things. But we have to get those out, because, like I said, every one of these stories generally sounds the same, and they all hurt. For me, they personally hurt, because it is something that has happened yet again that we feel like we talk about all the time, and for some reason it does not get heard.

Mr. SWALWELL. And Mr. Administrator, can I just ask—when I say teenagers I also include 19-year-old, and the issue I have seen there—even into the early 20’s—is that many parents—you know, they still consider the 19-year-old or the 20-year-old, you know, their son or daughter, and they lose their rights, you know, to make healthcare decisions for them, obviously, at 18. And so many parents have told me, “There has to be a way that I can fight for my kid, even though they are 19, 20 years old. I see that they are incapable of, you know, making healthy choices for themselves.”

And I understand, like, you know, it is the law, for very good reasons, that you are an adult at 18. But is there—do you have any ideas on what we can do if a parent sees a 19-year-old struggling with addiction, and they are now incapable of, you know, being a part of healthcare decisions or, you know, getting them, you know, the treatment that they need? I do not know if you have encountered this at all.

Mr. PATTERSON. I mean, look, we have, I think, an enormous problem in that college range. It is the big experimentation. Your parents are not over your shoulder every day; you are now amongst your peers. We see this especially in the issue with pharmaceutical pills. And there have been some very public stories about people buying what they believe is a Xanax or something else, and it is not.

So, this space is important and critical. And again, this gets back to an ongoing dialogue, and we in this country tend to like to put a blame on someone and fix it that way, by them being the problem. We all have to admit that this is a nationwide problem, and we have to stop looking at it: “It is this person, or it is that person, or it is this group.” And maybe this is now the time.

Mr. SENSENBRENNER. The gentleman’s time has expired. The gentleman from Pennsylvania, Mr. Rothfus.

Mr. ROTHFUS. Thank you, Mr. Chairman. It is good to see you, Mr. Patterson. The last time we spoke, you and your colleagues were hosting me for a briefing at DEA. I appreciate your participation here today and trust my colleagues are giving your testimony the way the weighty consideration that I think it deserves.

There are some scary portions of your testimony regarding fentanyl and other similar synthetic drugs. You also mentioned increased trend of fentanyl being mixed with heroin and traffickers now making counterfeit pills that appear like other pharmaceuticals, primarily CPDs, but actually contain fentanyl and other synthetics. What can Congress do to stop pill presses from coming into Mexico and the U.S. to illicitly produce such counterfeit pills?

Mr. PATTERSON. So, sir, we had put out a regulation some time ago, I guess probably about 9 or 10 months ago now, on pill presses that I think we are still trying to evaluate how helpful this is in trying to get people to acknowledge pill presses coming into the United States. I think there is space here, that the question is: how much are we able to impact through legislation these folks that are importing them?

I think that the production of counterfeit pills is a problem that we are going to struggle with for some time, and pill presses certainly are part of that equation. So, legislation that would be pro-

posed and that we can offer technical assistance on I think would be great.

Mr. ROTHFUS. So, you think there might be some room for some additional legislation to address this issue?

Mr. PATTERSON. I do, sir.

Mr. ROTHFUS. Well, we look forward to following up with you on that. Are we seeing a corresponding trend of increased overdoses from counterfeit pills with fentanyl?

Mr. PATTERSON. That is correct.

Mr. ROTHFUS. As far as, you know, looking where this is heading, do you see this getting significantly worse with these counterfeit pills?

Mr. PATTERSON. So, again, as the licit market; as we tighten that and make it harder and harder for licit pills to be there, I think that it naturally pushes and makes the potential for counterfeit pills to become much more of a problem for us.

Mr. ROTHFUS. Given the demand that is out there for fentanyl—and actually, I hear from back home where people look for tar-fentanyl—given how cheap these are to transport and produce, do you see criminal organizations switching from heroin to these substances?

Mr. PATTERSON. I do. The profit margins make them appealing to organizations that are willing to participate in selling.

Mr. ROTHFUS. You referenced Mexico-based transnational criminal organizations in your testimony like Sinaloa and how they are extremely violent, sophisticated, and with large networks. I am also very concerned about the growing interconnectedness of these TCOs globally and potential overlaps with terrorist organizations. Is the administration giving DEA and other agencies the resources and support you need to confront this interconnectedness?

Mr. PATTERSON. I think it is incumbent upon all the agencies that work under this administration to ensure that they are sharing information. We have good centers to do that that are already established, but I think, to your point, the world has gotten very small for these organizations, and the interconnectedness is there. That also gives us opportunity, though, as well.

Mr. ROTHFUS. Now, you know, when I started looking at this a number of years ago I was surprised to learn that the heroin that we are seeing, that it predominately is coming from Mexico; almost all of it. Is that still the case?

Mr. PATTERSON. It is. More than 90 percent of our seizures come from heroin produced in Mexico.

Mr. ROTHFUS. Well, internationally, in the world, 90 percent of the heroin is coming from Afghanistan. It is coming from Afghanistan, across the world, not just the United States, but worldwide.

Mr. PATTERSON. Certainly we do not see the presence in the United States, but they do produce a good portion of the rest of the world's heroin.

Mr. ROTHFUS. Does the supply coming out of Afghanistan impact the price in United States?

Mr. PATTERSON. Probably not.

Mr. ROTHFUS. We do have resources in Afghanistan, DEA resources, yes?

Mr. PATTERSON. We do.

Mr. ROTHFUS. Not nearly what we used to have, correct?

Mr. PATTERSON. No, sir.

Mr. ROTHFUS. Are there sufficient resources, in your opinion? Because I understand last fall we started targeting sites for manufacturer in Afghanistan—our forces did.

Mr. PATTERSON. Right. So, again working with the assets that we have and the resources we have, the best we can do is put intelligence out to that region for them to take action. I think part of the problem is other agencies, and the military has pulled out. It became much harder. You reference it; we are down obviously substantially in our people there. It is much harder for us to work in countries—

Mr. ROTHFUS. Well, given that, you know, most of the heroin in our country is coming from Mexico, do you think other countries that have heroin problems originating in Afghanistan are stepping up enough? Could they be doing more—other countries—with respect to interdiction efforts in Afghanistan?

Mr. PATTERSON. You are talking about internal, in their own country?

Mr. ROTHFUS. Well, also internationally, deploying resources to Afghanistan.

Mr. PATTERSON. No, I do not think that most countries are putting the resources they need to when they are production countries.

Mr. ROTHFUS. I yield back.

Mr. SENSENBRENNER. The gentleman from California, Mr. Lieu.

Mr. LIEU. Thank you, Mr. Chair. Thank you, Mr. Patterson, for being here. Thank you for your public service. You have an important job, and this is an important topic. I apologize, I was not here earlier as I at another hearing, so if I ask questions you have answered before, it is because I have not heard them.

When I was in California State Senate before Congress I worked on the opioid issue, and I helped put in the prescription drug monitoring program that California has, and you have put in your written statement that you view that as important for States to have these. I have a question. What happens if someone is in Nevada and gets a prescription, then crosses into California? Do those two databases talk to each other? How does it work when people cross State lines?

Mr. PATTERSON. I do not know specifically the State-to-State connections. That is probably the most critical piece of any PMP, that States, especially where they have borders, are able to see each other's. Because that is what we see all the time in the licit diversion of pharmaceuticals: People crossing State boundaries to essentially go pick that up. I was just out in California and speaking to our office out there; that is one of the better PMP programs that is out there.

Mr. LIEU. Is there any movement towards a national database that would prevent that, or is that too complicated to do?

Mr. PATTERSON. It should not be too complicated, and it is absolutely necessary.

Mr. LIEU. Would that require legislation, or could the DEA start doing that? What would be needed if we wanted to -

Mr. PATTERSON. Look, it could come in a couple of different forms. One, obviously—probably the easiest—would be legislation.

We have tried to push the States to have more interconnectivity. I think there are a number of people that have already put this forward, and again, we would be happy to provide assistance in what we see on that. I think the key is we hear this all the time from pharmacies and doctors as well, is that inability to see these patterns impacts them being able to make good decisions. So, where States fall short on this; this is the place that for me is highly problematic.

Mr. LIEU. Thank you. I also work on the issue of people able to buy opioids on Craigslist and other internet websites. Has that increased, decreased, or remained the same the last few years?

Mr. PATTERSON. I think, unfortunately, it is probably increased. I think you still see it across the spectrum of the internet. We are looking at, obviously, the darknet and Clearnet as to these locations, in essence for information that we can then use to target some of these folks. It would be nice if we could work better with the industry in having all of these sites pulled down. They recognize the challenges with that, but I think from a governmental standpoint, from a law enforcement standpoint, I think at some point we have to start dealing with known crimes that are occurring over the internet.

Mr. LIEU. If you have any ideas, let this committee and let us know regarding the internet trafficking. It is a hard issue. At the time, I was working on it, Purdue Pharma said they made oxycontin a different form that made it hard to use it legally. Did that work?

Mr. PATTERSON. I believe people figured out how to abuse that as well.

Mr. LIEU. Okay, so that did not really work.

Mr. PATTERSON. People with problems find ways to abuse drugs when they need to abuse drugs.

Mr. LIEU. In your written testimony you stated that there was a 70 percent increase in emergency visits related to opioids in the Midwest. You had some other regions; it was 20 percent in the Southwest. Why was there such a large spike in the Midwest?

Mr. PATTERSON. I think there are a couple things that factor into why we see spikes, and I do not necessarily know if it has changed it. Now, obviously, with emergency room visits we have seen a shift. We look at States that traditionally have not had this problem. I look at New Mexico, Utah, some of some of those States that have all of sudden had kind of a pick-up in this area, and it is incumbent upon us to be able to react and pay attention to that. That is why we are, unfortunately, tracking overdoses, overdose deaths, so that we can position ourselves to help those communities as it goes.

As we look at the Northeast and see some promise there, we have to be nimble enough to move our resources around to where we are seeing problems. But I think you see pockets showing up all over, and I know, certainly in terms of overdose deaths, sometimes those spikes end up being additional work that is being done in the ME or the coroner offices.

Mr. LIEU. Thank you. It also seems part of problem are patients who get prescriptions for doctors who treat pain, and then they get addicted to opioids. Do you know if doctors are being trained to rec-

ognize this more broadly, or is there continuing medical education or medical schools are onto this? Are they trying to train their doctors in a different way than, let's say, 10 years ago?

Mr. PATTERSON. I hope. I mean, look, we strongly support CME, or continuing medical education, in this space. I think that is a critical piece of what we see. DEA does outreach on a voluntary issue with the doctors, and I think the other thing that we are doing is trying to communicate much better with the 1.7 million registrants through the ability that we have to send them notifications and things; again, all voluntary. But I go back to the fact that I look at the vast majority of doctors: 99.99 percent are all trying to do right by their patients. So, I think the key is to, again, keep working on it educational process.

Mr. SENSENBRENNER. The gentleman's time has expired. The gentleman from Arizona, Mr. Biggs.

Mr. BIGGS. Thank you, Mr. Chairman, and thank you, Mr. Patterson, for being here today. It has been a very informative hearing. If I understand right, the vast majority of fentanyl and its derivatives are coming from China through Mexico across the southern border. Is that a fair takeaway?

Mr. PATTERSON. There are two different trends. So, you have bulk, you know, the larger quantities coming across the southern border. I think you have much more smaller packages coming directly in through China into the United States.

Mr. BIGGS. And I think in the second panel there will be a lady testifying of a young man who received it directly from China. But in this instance, I was curious about the role of Phoenix and the Tucson corridor for both transfers across the border. Can you elaborate on that a little bit, and also the efforts to interdict?

Mr. PATTERSON. All of those points of entry into our country have been blitzed with not just opioids but methamphetamine and other drugs coming across the southern border. Our border offices—so, you know, Texas, certainly Phoenix, or Phoenix division, San Diego, and El Paso, where these places are—it is the bulk of our work trying to deal with the mass quantities coming across the border, and that is where those folks primarily focus their efforts.

Mr. BIGGS. You talked about China, and then, as you squeeze the balloon, you are seeing that there is a potential moving to India, trying to fill a void if you are able to suppress China. And in your written testimony you elaborated quite a bit about China, and you talked about DEA liaison in in China. Can you tell me, what does that liaison do exactly, and how is that helping to slow the flow?

Mr. PATTERSON. So, our personnel that sit in China currently—the key is that intelligence sharing back and forth and an ongoing dialogue of things that they can do to help us in our process, and, frankly, training each other. So, we have had a number of them come over to understand from a chemistry side how to look at things that we are seeing. And a lot of this goes back to them trying to schedule the various analogues over in China, because we do see that when they do scheduling actions it has an impact in that country, which ultimately impacts us and what we are seeing here.

Mr. BIGGS. I am glad you said that, because that was my next question. Have the joint efforts produced some kind of positive reduction?

Mr. PATTERSON. They have, but again, these are chemists, and they will constantly change structures to avoid that. Part of the reason for us scheduling fentanyl as a class the way we did was to try and persuade China to do that in kind, to do the similar type of thing, and we are continuing to work through that effort. And they have done a number of fentanyl analogues and precursor chemicals, which is critically important.

Mr. BIGGS. Okay, so, if they open up the schedule or regulation of the schedule to a broader segment of fentanyl and its analogues, that is one way. But are they doing anything else to physically interdict shipments to the U.S., either through, like you are talking about, both the small transfers—direct mail, if I can put it that way—and bulk?

Mr. PATTERSON. Yeah, there have been seizures made over in China, and I think the key for us is being able to share data back and forth in a productive way of understanding the targets where those folks are shipping to the United States, and there has been a good pass of information back and forth in that realm.

Mr. BIGGS. Okay. You mentioned in your written testimony that in 2015 there was enhanced collaboration, and I am wondering what the next steps are with China. And what do you see the next steps working with China would be?

Mr. PATTERSON. I think the key for us is to get more resources there. We have a limited staff in China. Like I said before, you know, we are going to put additional personnel in Guangzhou, which is a big shipment point out of China, to try and really deal with these issues. But there is a willingness, certainly, at the agency level to participate and work fully in doing that.

One of the other huge pieces that we are trying to do is the precursors that are leaving China, going down into Central America, into Mexico, because that is a huge piece of not just the opioid side or what potentially could be an opioid problem, but the methamphetamine piece that we are dealing with in this country.

Mr. BIGGS. So, if we are successful in the Chinese interdiction, or at least to slow that down, and you anticipate maybe someplace like India or someplace else. What are the anticipated efforts that that are going to be necessary in those future countries?

Mr. PATTERSON. It will be taking that playbook that we learn from in China on how to work, essentially, the chemicals, which are the critical piece of this, and into India and other regions.

Mr. SENSENBRENNER. The gentleman's time has expired. The gentleman from Maryland, Mr. Raskin.

Mr. RASKIN. Thank you, Mr. Chair. Mr. Patterson, thank you for your service and your testimony today. Sixty-four thousand overdose deaths in 2016, which is more than the number of Americans who died in the entire Vietnam War; two-thirds of those 64,000 deaths opioid-related. Are we winning the war on opioid abuse? Are we losing it? Is it a stalemate? What is the report to the American people today?

Mr. PATTERSON. I think the issue that we have is, one, it is not a win. So, I mean, again, the number is problematic for me. I think what we see is that we are going to have to deal, you know, whether it is for the year or for in the next couple years, with a popu-

lation that has been abusing opioids and what that will mean for us as a Nation.

Mr. RASKIN. And, you know, in your effort you reported a huge number of Take Back drugs that DEA receives. What percentage of the Take Back drugs are opioids?

Mr. PATTERSON. So, we do not break those out, sir. I will tell you that I think, you know, most of us in our homes have had those bottles of opioids sitting around, so there is a percentage of it. You know, you could even put it at a small percentage and realize that we have a problem with overprescribing in this country in terms of the volume that we prescribe.

Mr. RASKIN. Okay. I found one academic article online just as you were speaking, because it sounded promising, that there were tons of Take Back drugs, but this one article says that only 0.3 percent of Take Back drugs are opioids, and most of them are aspirin or Flintstone vitamins. Is that right?

Mr. PATTERSON. I would find that statistic to probably not be accurate, sir.

Mr. RASKIN. What would you estimate it as?

Mr. PATTERSON. I do not know.

Mr. RASKIN. They are saying it is less than 1 percent.

Mr. PATTERSON. Even if you put it at 2 or 3 percent, it is still a pretty dramatic number of opioids. And we do not go through that and count up which it would be; our quest is to get the volume of prescription drugs out of the homes. And I do not know if we have any analysis, but if I find out that we do I will get back to you.

Mr. RASKIN. Please. I would be very curious to know. So, I was interested in your colloquy with my colleagues Johnson and Cohen about science, and I was glad to hear you testify in favor of science. Do you favor a rigorous and comprehensive scientific study about the addictiveness, the lethality, and the negative and positive health effects of marijuana?

Mr. PATTERSON. So, I think we have been pretty vocal about our belief in the research towards the medicine that could come from marijuana. I think our application process that we put in August of 2016 showed that we were trying to help the industry in terms of understanding where that research may go with giving additional growers.

Mr. RASKIN. So, you would favor a comprehensive scientific health study on the effects of marijuana?

Mr. PATTERSON. Absolutely.

Mr. RASKIN. Okay. Let me ask you. We are in such a terrible situation with the opioid crisis as well as with drug abuse generally, as you are saying. Tell me how America's experience with liquor prohibition informs your analysis of the most effective strategies we can be using in order to address this public health crisis.

Mr. PATTERSON. I am not your person to talk about liquor analysis, so I cannot help you on that topic, sir, in terms of how that correlates with, I think, the drug issue in the United States.

Mr. RASKIN. Okay. I ask this question not rhetorically but seriously: do you favor, speaking either as the head of the DEA or personally, the 21st Amendment and the repeal of prohibition of alcohol? Obviously, there remain tens of thousands of people who die

every year from alcohol abuse, both in terms of health effects but also because of drunk driving on the highways. Do you have a position on that?

Mr. PATTERSON. To repeal it?

Mr. RASKIN. Well, the 21st Amendment repealed prohibition, the Eighteenth Amendment. Do you support the 21st Amendment, or do you think we made the wrong decision then? Would it have been better to continue with prohibition of alcohol?

Mr. PATTERSON. I think this goes back to it is a personal use decision to be made. So, I mean, I would not sit here and tell you that I think that was a bad decision. I do think that all these factors, like I said, we all have to be the adults in the room.

Mr. RASKIN. And I appreciate your answer very much, because I certainly tell my kids that I think using alcohol is a bad decision. We have a relative who was killed by a drunk driver; I feel very seriously about it. On the other hand, I think that our experiment with prohibition failed because there was a public demand for it for the reason you say, that people like to experiment with their consciousness in different ways. Do you think that, after decades of criminalizing marijuana, that experiment in prohibition has proven to be a failure, and it is time to call it off?

Mr. PATTERSON. So, I will give you my personal opinion on this, which is I think over the last decade my opinion has changed on this. Ten years ago, I may have told you yes, and I think now, more than ever before, as I see what fuels some of our addiction problems in this country, starting with marijuana, I have gotten a much more stronger opinion as to that. I believe that we are now in a dangerous environment in terms of what we are doing with legalization.

Mr. ROTHFUS [presiding]. The time of the gentleman has expired. The chair recognizes the gentleman from Louisiana, Mr. Johnson, for 5 minutes.

Mr. JOHNSON of Louisiana. Thank you, Mr. Chairman. Mr. Patterson, thanks for being here. As you know, an ISO was issued on Friday afternoon against a large distributor in my district, accompanied by a DEA press release. And I just have two kind of categories of questions related to that, one with regard to the patients that are affected by this ultimately, and second, with regard to process.

Regarding the patients, by Monday I had already received multiple constituent inquiries about all this, including a local hospital who said that this was creating a serious situation for them and an affidavit from the Louisiana Independent Pharmacy Association expressing the immeasurable impact this decision is going to have on the many hospitals and pharmacies and patients throughout my State, and really the Nation, because this distributor serves many States around the country. Mr. Chairman I would like to ask unanimous consent to enter into the record a copy of this affidavit.

Mr. ROTHFUS. Without objection.

Mr. JOHNSON of Louisiana. Thank you. The affidavit is from the CEO and president of Louisiana Independent Pharmacy Association, and he says in a three-page affidavit—the most important language, I think, is at the end. He says, “This suspension has already caused a disruption in the supply chain for our members”—

all the independent pharmacies—"and is currently impacting the delivery of care to the patients those members serve.

Affiant believes that continued suspension will worsen the problem, causing patients served by independent pharmacies to have their care delayed and perhaps be denied. The most significant impact is to the patients who are unable to find the pharmacy healthcare and necessary prescription drugs in their community and to find the continuity of care to help maintain and improve their health and health outcomes."

The question is: when an immediate suspension order is issued, is there any consideration at all given to the patients that rely on these lifesaving drugs that are effectively left without access to critical medication overnight?

Mr. PATTERSON. There absolutely is.

Mr. JOHNSON of Louisiana. I mean, what did you do in this situation, by way of example?

Mr. PATTERSON. So, again, as we spoke about earlier, the issue for us here is we have not heard from these same hospitals that have now provided—and I have not seen that affidavit—an affidavit, obviously for the temporary restraining order that is going to be filed today, and there is a process by which the company down there can go and go about that. We have not heard the same concerns, as—

Mr. JOHNSON of Louisiana. Let me stop you, because I am short on time. Let's just apply common sense here. Let me assume, for the record, that you have not heard since this happened Friday afternoon, and we are here on Tuesday morning; you have not had time to hear from a lot of these folks. Would you take my word for it that many are affected? And if you do not take my word for it, use common sense.

This distributor, for example, supplies hundreds of hospitals in Louisiana and the surrounding region, hundreds of Louisiana pharmacies totaling hundreds of millions of doses per year. So, is it safe to say that that puts patients affected, I mean, at least in the numbers of tens of thousands, if not hundreds of thousands of patients, in some immediate jeopardy? Some of those are lifesaving medications, are they not?

Mr. PATTERSON. I understand that, and simply what I will counter with you is that the hospitals or pharmacies that we have talked to have secondary supplies, as most generally do.

Mr. JOHNSON of Louisiana. How many have you spoken to on this case?

Mr. PATTERSON. I do not know. I think less than 10 have reached out to us. So, every one of those people that have the ability to distribute narcotics or distribute schedule I or schedule II, in this case, have backup sources, and those that do not have already reached out to DEA to seek remedy.

Mr. JOHNSON of Louisiana. Well, this affidavit from the Louisiana Independent Pharmacy Association, they have at least 85 pharmacies, about 82 million prescriptions filled each year, and they are directly affected. So, you might want to consider that. I am concerned about going forward in other cases, before you issue an ISO, which I understand is a rare occasion, there ought to be some regard paid to all these patients.

I have a lot of constituents who are literally some on their death bed today; I am not using hyperbole. They cannot get their necessary medications because the DEA decided to do this. I am concerned about the process. And let me ask you, in a case like this, would the DEA consider, as they have in the past, this example? This company, for example. Will they have an opportunity to offer a remedial plan rather than just instantly removing access to millions of doses a year for all these patients? Are they going to have a chance to correct?

Mr. PATTERSON. There is. There is a process in which they will have the chance to correct. But I go back to the fact of if you have a company that shows woeful neglect and continued bad behavior, we have to hold these folks accountable.

Mr. JOHNSON of Louisiana. Well, it is not for you and I to litigate the specific facts of this case.

Mr. PATTERSON. I agree.

Mr. JOHNSON of Louisiana. That is for the court. But is it a normal process, a normal procedure, for the DEA to allow an alleged offender to present a remedial action plan?

Mr. PATTERSON. The corrective action plan is part of the process.

Mr. JOHNSON of Louisiana. And would they be afforded that in this case?

Mr. PATTERSON. Yes.

Mr. JOHNSON of Louisiana. I am almost out of time. One more question about process: if it comes to light that the DEA acted prematurely or that evidence did not support the claims in this case, for example, are there processes in place to offer restitution? So, for example, if a company goes out of business because of this delay, what remedy do they have against the Federal Government? I am out of time, but you can answer.

Mr. ROTHFUS. The gentleman's time has expired. The chair recognizes the gentlewoman from California, Ms. Bass, for 5 minutes.

Ms. BASS. Thank you. I actually want to follow some of the questioning of my colleague here. And I know, you know—excuse me—we are back and forth; we all have hearings the same time, and some of these questions you might have been asked before.

But I really wanted to talk about the drug manufacturers, even before they get to the point of distributing it. You know, this problem has not existed forever. I mean, it has been many years since I worked in the medical field, but when I was working in the medical field we did not have this problem.

And so, before the drugs are even distributed to individual pharmacies, what relationship do you have with the manufacturers to begin with? Because one has to question why they are manufacturing millions and millions of opioids when they were not needed before? So, how do you work at the point of manufacturing with the manufacturer?

Mr. PATTERSON. I think this is really where the rubber meets the road on this issue. We can fight this downstream, right, with doctors and pharmacies and diversion of pharmaceuticals, but you have to elevate this conversation back to the prescribing practices the United States.

Ms. BASS. Well, the prescribing practices, absolutely. I agree with you. But I am talking about even before the prescribing practices.

I mean, the companies that make these drugs: does the DEA put pressure on them for producing and manufacturing the volume that they do?

Mr. PATTERSON. So, under the quota process we do, but what I was going to finish up on that last sentence is the prescribing practices cannot be driven by industry. They need to be driven by the medical community, and I think that is where the disconnect is there.

So, DEA has done more and more education with distributors, and even in the manufacturing space, to explain the problem, but where this has to change is in the prescribing practices, because there are corporations that are making pills. As long as that continues to get put out in the same manner, we have a problem.

Ms. BASS. But you do know the relationship, right? So, you know that the distributors go to doctors' offices and promote the prescribing practices? I mean, when I listen to my colleague there talk about the tens of thousands of people that need opioids in his district, I really have to raise the question: do they really?

Mr. PATTERSON. You are asking the wrong guy that question, because I will give you the law enforcement answer, which is no. I mean, it does not need to be. And there are some good studies out there to show that opioids—the VA just did one where opioids had the same impact that Tylenol did when you do blind studies. So, I mean, there is science out there, again, to go back to that word.

Look, we have to change our culture, and that is why I said this is not a one-size-fits-all answer to anything. We have to change a culture in this country. But it goes across all of us. Right? So, whether it is legislation capabilities to fix this problem; whether it is, you know, the pharmaceutical industry ultimately recognizing the harm that is being done; whether it is law enforcement and their efforts; I mean, we all have to work collectively together on this problem.

Ms. BASS. Yeah, I agree with you, but at some place we have to figure out how to hold the companies responsible, because they push the medication on the doctors. They hand out free supplies; they put on lunches and dinners. I mean, I worked in many medical offices before, and I also have a hard time understanding.

And I hear about—I do not know that this exists in Los Angeles, but I do think it exists in a number of your districts—where you have these “pharmacies,” and people will get off the freeway offramp and go pick up huge volumes of opioids that there is no way in the world you can say that that has a medical use, and that is allowed. And I do not understand that. I do not understand how those type of pharmacies can even exist.

Mr. PATTERSON. No, and that is where law enforcement does have to step in. So, once you have moved from the manufacturing into the distributor and then the pharmacies and the doctors and that relationship there, we have to do a much better job. And I know you had not been here earlier, but where we interact with States and then using HHS data and others to find these in a real, efficient, and timely manner to stop that harm, because that is ultimately where those pharmaceuticals get introduced to the general public.

Ms. BASS. Right, but they would not have those if the manufacturers were not producing it at such a volume. Thank you.

Mr. PATTERSON. Thank you.

Ms. BASS. I yield back.

Mr. ROTHFUS. The gentlewoman yields back. The chair recognizes the gentleman from Iowa, Mr. King, for 5 minutes.

Mr. KING. Thank you, Mr. Chairman. First, Mr. Patterson, I want to thank you for your direct testimony, and my sense of your testimony here today is you came here to help inform this Congress of the job we all have ahead of us. Sometimes we get evasive witnesses, and you are not one. So, thank you. Maybe I would start with this. Do we have a decent idea on how many drug misusers we have in America?

Mr. PATTERSON. Overall, or for in the opioid space?

Mr. KING. Overall.

Mr. PATTERSON. Overall, it is obviously in the millions, probably, you know, 10 or so million, 11 million.

Mr. KING. Okay. And I am looking at a number around 11.5 million, so that is in the zone. And I am not going to ask you to answer the components of this now, but is it something you could put together for us to build us a pie chart that would tell us the overall population of drug misusers, and then break it down by the different types of drugs so we could get a better handle on the scope of this drug abuse problem we have in America?

Mr. PATTERSON. I would be happy to do that, sir.

Mr. KING. Good. I appreciate that, and I will be looking forward to seeing that. Do we know what the street value is of the illegal drugs consumed in America? The illegals?

Mr. PATTERSON. Yeah. Across, again, the platform of all narcotics, yes, we do.

Mr. KING. What is that number? The street value?

Mr. PATTERSON. The street value?

Mr. KING. Yes.

Mr. PATTERSON. Maybe I am misunderstanding your question. I thought you meant like what someone would pay for a dose of a certain thing. You are talking about the total off—

Mr. KING. No, I am interested in how many dollars out of our U.S. GDP are spent on illegal drugs? What does it do to our economy?

Mr. PATTERSON. It is a massive drain on our economy.

Mr. KING. Do you have to guess at that, though? I mean, I saw a number reported by Fox about 4 years ago of \$40 billion; I saw a number reported, \$60 billion. We have got \$60 billion or more that are transferred south of the border for some reason. Some of that is laundered money. So, do you think that number is up from those estimates I am seeing?

Mr. PATTERSON. I do, but part of the issue here is whenever you see these numbers it depends on what is being factored into it. Right? A lot of them do loss of wages; loss of productivity; cost to, you know, Medicare, Medicaid, and prescription; all these other things. So, I would be more than happy to come back and give you some real numbers as to what we see.

Mr. KING. I would very much like that, and we can flesh that question out in a little more detail, perhaps, off the panel. Let's

see. What percentage of the illegal drugs consumed in America come from or through Mexico?

Mr. PATTERSON. I would suggest that, for the bulk number, probably of the vast majority.

Mr. KING. If I remember a previous discussion with DEA some years ago, their estimate was between 80 and 90 percent. That would be in the zone that you understand today?

Mr. PATTERSON. I think that is certainly a fair estimate.

Mr. KING. Okay. And then, what percentage of the illegal drug distribution chains include at least one link that is an illegal alien?

Mr. PATTERSON. One link that is an illegal alien?

Mr. KING. Yes.

Mr. PATTERSON. I would assume almost all of them.

Mr. KING. That has been consistent with the responses I have gotten with others as well. And so, then, do we have any data? I know some of these estimates you mention address the American productivity, so we can flesh that question out a little bit more, too. I want to get a better scope on what it does to our economy; what it does to our families; the impact on our children. I do not see very good estimates of that that are quantified, and that might fall in the line of sound science.

But you made a statement here that—first, I want to put another thing into your ear. If I do the math on this, 11.5 million drug misusers in America; 64,000 of them died in the year 2017. So, if I just divide the 64,000 into 11.5 million, I come up with a number one out of 180 drug—I call them drug abusers—die to overdose in any given year. If they are going to use drugs for 10 years, they have got a 1-in-18 chance rather than a one-in-180 chance. In 20 years, it is one in nine. That is the scope of the devastation that we are seeing in our society.

But you made a very important point here, and I think it is the most important one of the whole panel, and it says, “We have to change the culture in this country.” That really does, I think, ring the bell as close to the center of the truth that we are dealing with here, as complex as it is. And so, I want to pose an approach to this, and then it is this: if society were determined to solve this problem, I believe we would do this.

First, we would test in the workplace, then we would test in education, and we would test certainly in government as well, and then we would test in welfare. And if we did that, theoretically, we would dramatically reduce the drug abuse in each of those arenas. Those left would be the dealers and stealers, and they would be the ones that law enforcement would contend with, and we should be able to handle that if that is the only ones left out of the universe.

And so, I pose that, but the big question still is, how do we get the culture change to accept such a change? And I think recognizing the reality of those deaths that we are having and the damage to our society and quantifying it would be a very good step to follow along. I look forward to continuing to work with you, and I appreciate the job you are doing and the testimony that you provided today, Mr. Patterson. Thank you, and I yield back.

Mr. ROTHFUS. The time of the gentleman has expired, and the chair recognizes the gentleman from Florida, Mr. Deutch, for 5 minutes.

Mr. DEUTCH. [inaudible].

Mr. GAETZ. Mr. Chairman, can I ask the gentleman to turn his microphone so I can hear him?

Mr. DEUTCH. I apologize. Thank you. Florida was the epicenter of the explosion of opioid abuse over a decade ago. In Florida, opioid addiction-related deaths increased 80 percent from 2003 to 2009. Addiction is cruel, ruthless, and unforgiving. Opioid pills prescribed after an injury or to treat chronic pain can too easily drag anyone in pain into the depths of addiction. The crackdown on pills has meant turning to street drugs for thousands of Floridians.

Mr. Chairman, we have used mandatory minimum sentences as 1951, and we boosted penalties through the last 3 decades of the twentieth century at the height of the war on drugs. But tough mandatory minimums for drug charges have not cut off access to drugs in the past, and they are not likely to stop the brutal tide of overdoses that we are facing today. I would like to share a story that I heard from Broward County public defender Howard Finkelstein, just to caution the work of this committee.

He told me about a 40-year-old woman in Broward County, Florida, who had no criminal record and was unable to work due to a disability. She was described by those who knew as a sweet lady. After being pursued multiple times by a confidential informant seeking pills, she gave in. She sold 35 Lorcet pills, a blend of Tylenol and hydrocodone, to the informant. After living 40 years without a criminal record, she was sentenced to a mandatory minimum sentence of 25 years in prison.

Does keeping this woman in prison until she is 65 do anything to help her, to help her family continue without their mom in the home, to help others who are addicted, to our society now paying for her incarceration? This committee needs to take a close look at the impact of our policing and prosecution policies around the country that do a lot to drive up the numbers of arrests, convictions, and fill our prisons, but may not be helping treat addiction or save lives.

Hyper-deadly drugs like fentanyl are finding a way into our communities. The rise of these synthetic opioids requires that we meet this challenge on its own terms. Their extreme potency makes it harder for law enforcement to stop them. With a few clicks on the internet, there is no longer a need for cartels or street dealers. Last year, Florida passed a law to impose mandatory minimum sentences for possession of fentanyl and other synthetic drugs, but evidence shows that boosting punishment is unlikely to stop the spread of these drugs.

This March, I held a roundtable on the opioid crisis with my colleague, Congresswoman Wasserman Schultz, in my district to talk with law enforcement, public health officials, and families about the response to the needs of our community. And what we heard was that, fundamentally, addiction is about mental health, and to save the lives of those in the grip of addiction, we need to get them help, not lock them up. Criminalizing addiction locks people out of our healthcare system and cuts off a real chance at recovery.

We need a comprehensive solution. I think we have delayed too long in getting a comprehensive response through the House to address this crisis. We need to focus on broadening access to addic-

tion treatment that would truly save lives. Instead, just over a year ago, my Republican colleagues celebrated a vote to overturn Obamacare that would have taken comprehensive coverage from over 20 million people. Some Republican States, including my own State of Florida, have failed to expand access to care with Federal dollars by expanding Medicaid.

Expansion can allow more than 800,000 Floridians to gain access to comprehensive health coverage that includes mental health and substance abuse treatment as essential benefits. It is estimated that 300,000 of those 800,000 Floridians already need some level of care right now, and they are struggling to get it, but, apparently, my colleagues who voted for Trumpcare last year think that we should go the other direction, that we should end Medicaid expansion and fundamentally change the program structure.

It would replace guaranteed funding with a limited account for opioid treatment; to lock recovery clinic doors to those who desperately need help. It will undermine the emergency response needed to pull up the deep roots of Florida's addiction crisis. Twelve Floridians are lost every day to the scourge of addiction. It is a public health emergency, and treatment can help save the lives of our fellow Floridians.

Mr. Patterson, I would just ask you, given your experience, do you think a broader access to substance abuse and mental health coverage would help people struggling with addiction treatment stay in treatment?

Mr. PATTERSON. So, we are talking about addicted populations? You had a couple things combined in there.

Mr. DEUTCH. Okay.

Mr. PATTERSON. The sentencing issues put aside, I think for people that are not distributing drugs—and, obviously, DEA does not, you know, look at a certain level.

Mr. DEUTCH. I understand.

Mr. PATTERSON. The treatment availability should be there for those that are addicted to drugs. I think distribution is a different issue, though, than what you just talked about.

Mr. DEUTCH. Thank you very much. Thank you, Mr. Chairman.

Mr. ROTHFUS. The time of the gentleman is expired. The chair recognizes the gentleman from Florida, Mr. Gaetz, for 5 minutes.

Mr. GAETZ. Thank you, Mr. Chairman. Earlier in your testimony you said in response to a medical marijuana question, "We have a substance abuse problem, and we do not want to add to it." Is it the position of the DEA that democratizing access to medical marijuana will add to the substance abuse problem in this country?

Mr. PATTERSON. I think it is a conversation that we have to have. Again, when you say medical marijuana, is it a medicine that has been made from marijuana, or the current standard of the State has now said that marijuana is medicine?

Mr. GAETZ. Well, in either of those circumstances. But let's just take the circumstance where a State is said marijuana is medicine. Is it your view that that adds to the substance abuse problem?

Mr. PATTERSON. It is.

Mr. GAETZ. Opioids are prescribed principally as a chronic pain solution, right?

Mr. PATTERSON. Correct.

Mr. GAETZ. The National Academy of Sciences issued a report in 2017 entitled *The Health Effects of Cannabis and Cannabinoids*. Are you familiar with that work product?

Mr. PATTERSON. No, sir.

Mr. GAETZ. I will quote from it. It says, "There is conclusive or substantial evidence that cannabis or cannabinoids are effective for treatment of chronic pain in adults." Do you have any basis, scientifically or from any evidentiary standpoint, to disagree with that conclusion?

Mr. PATTERSON. Again, this is why I think we always talk about the research of the benefits of marijuana.

Mr. GAETZ. So, you support research into medical marijuana?

Mr. PATTERSON. We have said that all along, that we support the research of marijuana.

Mr. GAETZ. And after you implemented a rule in August of 2016 pushing the Department of Justice to create more research-based cannabis, they have not issued any more of those permits, have they? Or have not granted any.

Mr. PATTERSON. So, they have not been granted, but I think there is an important distinction that has to be understood. So, when we put that rule out it was in the efforts to help the research community.

Mr. GAETZ. But if none of the research permits have been granted, how has it helped them?

Mr. PATTERSON. Because there is an issue with how we put that solicitation out of that rule out, and that has to do with the single treaty, which I know, you know—I had to get up to speed on it. I did not understand it at first when I was told. But the reality is that the department has worked through this; once they have made their ruling, DEA will figure out how this looks moving forward.

Mr. GAETZ. But you have taken the position that medical cannabis—in response to my questions—adds to the problem. So, you have also agreed that opioids are prescribed for chronic pain, so I want to use my remaining time to delve into the extent to which medical cannabis in some places has been used as an appropriate substitute.

The Minnesota Department of Health had a research project with over 2,000 patients who had intractable pain that used medical cannabis. And those patients saw opioids prescribed at a rate 38 percent less than people who were not using medical cannabis. Do you have any basis with which to disagree with that finding that those patients saw a reduction in the need for opioids when they had access to medical cannabis?

Mr. PATTERSON. So, I am not familiar with that study. I think there are a number of studies out there that talk when people are presented, whether—I guess it would be with medical marijuana or with Tylenol or others—that there are many alternatives to opioids.

Mr. GAETZ. So, do you acknowledge, then, that medical marijuana is an alternative to opioids?

Mr. PATTERSON. No, I am saying I do not know that study. So, I mean—

Mr. GAETZ. What studies show that medical marijuana would increase the use of opioids? Are there any?

Mr. PATTERSON. I do not know.

Mr. GAETZ. So, you are the acting administrator of the DEA; you cannot cite a single study that indicates that medical marijuana creates a greater challenge with opioids. And you are unaware of the studies, including studies from the National Academy of Sciences, that demonstrate that medical marijuana can be an acceptable alternative to opioids. Is that what I am understanding?

Mr. PATTERSON. Yes.

Mr. GAETZ. The American Geriatric Society surveyed patients, and they found a 68 percent reduction in opioid use. Are you familiar with that?

Mr. PATTERSON. No, sir.

Mr. GAETZ. In New Mexico, medical cannabis patients saw a 70 percent reduction not only in opioids but in all scheduled drugs. Is that something you are familiar with?

Mr. PATTERSON. No, sir.

Mr. GAETZ. So, the sum of evidence from the States that have democratized access to medical cannabis—have you analyzed any data that looks at opioid death rates in medical cannabis States versus nonmedical cannabis States?

Mr. PATTERSON. No, sir.

Mr. GAETZ. You indicated earlier, and I am grateful for it, that that is an appropriate conversation to have. I wanted to take my last few moments to thank Chairman Goodlatte; he has signed on as a cosponsor to the Medical Cannabis Research Act, which I think builds on the work of DEA to push the Department of Justice to stop their obstruction when it comes to researching medical cannabis. Can we count on the DEA to be a partner in pushing for more research so that we can either validate or dismiss this information we are receiving from States?

Mr. PATTERSON. And I think we have been consistent in that message for the last number of years.

Mr. GAETZ. Thank you, Mr. Chairman.

Mr. ROTHFUS. The time of the gentleman has expired. The chair recognizes the gentlewoman from Washington, Ms. Jayapal, for 5 minutes.

Ms. JAYAPAL. Thank you, Mr. Chairman, and thank you, Administrator Patterson for being here and for your work. I am unfortunately going to miss the second panel, and so I did want to just raise something before turning to my questions for you that I was going to say in the second panel.

And that is in my hometown of Seattle we recognized early on that we cannot arrest our way out of the situation, not just for opioids but on other low-level crimes as well, and in 2011 we launched the Law Enforcement Assisted Diversion program, the LEAD program. It was the first known prebooking diversion program for people arrested on narcotics and prostitution charges in the United States, and it is a very, very unique collaboration between local law enforcement, prosecutors, treatment services, the Department of Corrections, public defenders, and the ACLU and others.

And actually, among LEAD participants, 60 percent are less likely to be arrested; 89 percent more likely to have a place to live; 46

percent more likely to have a job in the 6 months following enrollment.

Mr. Chairman, I seek unanimous consent to enter into the record an article on LEAD, as well as a University of Washington study on the efficacy of LEAD.

Mr. ROTHFUS. Without objection.

Ms. JAYAPAL. Thank you. And I want to thank Mr. Sensenbrenner, Mr. Johnson, and a number of Republicans that helped me to get some funds into the last budget omnibus spending bill that expands the LEAD program across the country into some of these critical areas that are dealing with opioids.

So, Mr. Patterson, according to a 24-page report that was prepared by the DEA last May, drugs frequently do not enter through land routes. The report provided numerous examples of this, noting, for instance, that the majority of heroin found in New Jersey is primarily smuggled into the United States by Colombian and Dominican groups via human couriers on commercial flights to the Newark International Airport.

You have been quoted previously saying, and this is your quote, "This is not an easy thing to fix. If there were two or three answers to solve this problem, then I should be fired. There are thousands of things that need to be addressed."

And I wanted to bring up the fact that there have been many attempts to assert, by the White House and by Republican colleagues on the other side, that building a border wall is somehow going to solve the problem of the flow of illegal drugs into the United States. Did your intel report recommend building a border wall as a solution to the flow of drugs into the United States?

Mr. PATTERSON. That report—I do not recall specifically what its recommendations were—I will simply sum it up this way: Our current ports of entry are access points into this country where there is staffing. Now, I am not a border security person; I think we need secure borders, and ultimately, what that looks like I am not the right person to answer. If there is additional security on the border that allows additional CBP assets or others to work those points of entry, that is a critical piece.

Ms. JAYAPAL. Thank you, Mr. Patterson. I do have the report, and I can tell you it does not say anything about a border wall as a solution to the problem. In fact, does your own report not detail that, as you just said, drugs are entering the country not on the backs of human smugglers but actually in small quantities? Even if they are crossing the southern border, they are in the backs of legal vehicles; they are hidden away in little pieces; they are in tractor-trailers.

They are not being transported by individuals across the border, and a border wall that stops people from coming in is not the issue. It is these legal ports of entry that people are manipulating to get those drugs across. Is that correct?

Mr. PATTERSON. I do not discount that you do have people that smuggle smaller quantities across the border, you know, whether it is through their person or other means. I think the bulk that is coming out of Mexico is coming through the points of entry, or, as you brought up, other routes that we see: The Dominican Republic; directly out of China; you know, those types of events.

Ms. JAYAPAL. Thank you. So, would you support increased funding, for example, for the Coast Guard, something that the President had initially recommended decreasing funding? But the Coast Guard is actually responsible for the interdiction of drugs within our waters, for example.

Mr. PATTERSON. The Coast Guard is one of our most important assets when it comes to the control of especially cocaine coming out of South America, and I believe they could use more resources.

Ms. JAYAPAL. So, let me reiterate that a border wall does not solve the problems of drugs across into the United States. You have mentioned many times during your comments, and I have read some comments you have made before, that addressing demand is absolutely critical here. Can you comment on—and you only have 10 seconds—but the one or two most important things to address demand?

Mr. PATTERSON. So, demand, I think, comes through education, and the other piece is the conversations about prevention before it starts. I mean, I think a lot of the issues that come out in this is that once substance abuse starts, treatment is hard. Not necessarily in all drugs, but in most drugs, it is.

Ms. JAYAPAL. Thank you Mr. Patterson. I yield.

Mr. ROTHFUS. The time of the gentlewoman is expired. The chair recognizes the gentleman from Rhode Island, Mr. Cicilline, for 5 minutes.

Mr. CICILLINE. Thank you, Mr. Chairman. Thank you, Mr. Patterson. First, I want to thank the chairman and the ranking member for calling this hearing. And it is important to remember that drug overdose is the leading cause of injury deaths in the United States; 115 Americans die every day due to opioid overdose. In my home state of Rhode Island, last year we lost almost one Rhode Islander per day to this disease, and nearly half of those overdose deaths involve a prescription opioid.

And so, my first question is, my understanding is that there is a discrepancy between the Comprehensive Addiction Recovery Act, CARA, and the current DEA regulations on providing for a partial fill of a prescription. In the past partial fills could be made at the pharmacy when a pharmacy did not physically have enough quantity on hand. Under CARA, a partial fill can be made under several circumstances, including when a State has acted to limit prescriptions of opioids or a patient or prescriber requests an initial fill of an opioid prescription for a shorter time period.

This sort of discrepancy between the law that is CARA and DEA regulations is problematic for pharmacists. Can you tell me what steps the DEA is taking to bring its regulations into alignment with CARA and when we might expect those regulations to be promulgated and updated?

Mr. PATTERSON. I appreciate the question, sir, and it goes back to something I started off with, which is States in a lot of cases have already taken this on their own backs of fixing the, you know, State laws for much smaller initial prescriptions. And this is something that we obviously still owe related to our regulations in this space. It is critically important; we need to get it done. And it also, then, impacts the additional issues of quota and other type—

Mr. CICILLINE. It is on your agenda. Thank you. The Responsible Drug Disposal Act of 2010 gave authority to DEA to enable pharmacies and other entities who are licensed to handle controlled substances to collect unused medication from the public and destroy it. However, the Government Accountability Office found very low participation among pharmacies.

I am just wondering if you have a sense of why that is. Do you think it would be beneficial if more pharmacies participated, and what can we do to accelerate that participation?

Mr. PATTERSON. So, we have seen an uptick in the collection. I think it poses a number of challenges that—you know, distribution points, pharmacies, others—whether it is safeguarding or other issues that surround that. But I think this is a place where, again, our educational presence and us talking to people about getting these medications brought back in is absolutely critical, because we see so much diversion happening in that space still.

Mr. CICILLINE. And if you think there are things we can do to further enhance that, I trust you will let us know. Mr. Patterson, does the DEA offer any ongoing medical education or training to prescribers on the dispensing or prescribing of opioids? And if not, do you think your agency, if charged with that, has the ability to provide that kind of medical training?

Mr. PATTERSON. So, we obviously provide information through our outreach to both prescribers and to pharmacies as well as distributors and manufacturers. We cannot mandate CME, but I think it is probably one of the most valuable things that can be done. So, we use our registration or distribution list of our registrants to send out information. Again, I cannot make it mandatory that they—

Mr. CICILLINE. But there is no question. You think it would be beneficial if people—

Mr. PATTERSON. Absolutely.

Mr. CICILLINE. Okay. And my final question, because I know I do not have a lot of time. You mentioned that the DEA could do better in terms of disrupting or taking note of these distributors who are distributing orders that deviate from the norm, or unusual frequency, unusual quantities, and that there is in place only a civil fine; DEA needs to do a better job of that. Are there things we can be doing in Congress to give you additional resources or authority?

It seems to me if, as you described, it is just a cost of doing business, then that is not a great disincentive to do it. If, in fact, loss of licensure, criminal penalties, or other things were in place—why is DEA not doing a better job in the current framework, and what can we do to strengthen your ability to try to interrupt or prevent these distributions which are clearly problematic?

Mr. PATTERSON. I think it is a valid question, and hopefully I did not misspeak. Obviously, we have criminal tools in this space as well. I think probably all too often, though, we end up at the point of having a civil fine. And some of those are important, because again, as we heard earlier from one of the members, the change of a distribution center has a ripple effect. We know that, and we are cognizant of that.

There are times, however, when we have egregious behavior that we have to deal with, and I think there is definitely a change in the philosophy in the prosecutor's offices and with DEA, that we need to hold people more accountable than just a civil fine.

Mr. CICILLINE. Thank you. I yield back, Mr. Chairman.

Mr. ROTHFUS. The gentleman yields back. The gentlewoman from Florida, Ms. Demings, is recognized for 5 minutes.

Ms. DEMINGS. Thank you so much, Mr. Chairman, and Mr. Patterson, thank you so much for the job that you do. It is a moving target. One day you are the answer, and the next day you are the problem. But I think that not only should DEA be held accountable, but all of the stakeholders, including Congress, should be held accountable for the job that we do.

You talked a little bit about that with my colleague from Rhode Island, about some of the things that DEA could do differently in terms of accountability. I heard what you said to him, but could you just kind of elaborate just a little bit more on that particular issue? And how can Congress, as we deal with this crisis throughout our country, be more accountable as well in terms of helping to find solutions and not creating more problems?

Mr. PATTERSON. Right. Let me start with the second piece first. So, in the legislation space that provides us great assistance, and I recognize that every piece of legislation sometimes has its unintended consequences. There are more than 60 pieces that are out there right now in this opioid space, and you all should be applauded for the efforts you have done.

And we all need to make sure that when we see those unintended consequences, as we have seen in the past, we have to be very vocal about it with you so you know what is going to happen. DEA and HHS debate all the time over research, and research is critically important in this space as well, and we have to find common ground to address these problems.

Going back to the things that DEA needs to continue to do better—and this is the piece—and I greatly appreciate this hearing, actually, today, because I feel like this is one of those good days as opposed to the day that we are the enemy. We have made tremendous strides, I think, in this space over the last handful of years. So, it is using our data; it is figuring out ways to share our data. Right?

We have all had these stovepipes of information that we, for whatever reason, either do not feel we can share or cannot. The law enforcement community is all pulled together behind this, and you do not see the badges anymore; what you see is a combined effort. And I feel this even across the industry. Right? I mean, it truly feels like the moment where people are understanding that this is a disaster, and it is not just a talking point for people. It is a true movement of what is said. So, as a 30-year veteran of drug law enforcement, it is nice to see that even though a decade ago we had 35,000 overdoses, for whatever reason, this has truly woken everyone up.

So, our participation with our State and local partners, all these other things—but DEA has to continue to be more aggressive in terms of what it does. And not aggressive in a reckless way, but again holding people accountable, making sure that we are out-

spoken on where we see issues, and, frankly, not being afraid to push into that space.

When we talk about quota, quota is a tricky space for us to deal with. And all of these are balancing acts that we are going to have to deal with, but we should not be embarrassed—we probably should be embarrassed—but the mistakes that we made the past we learn from, and we have to move forward on that. That is why I appreciate today to at least highlight some of those things in what we are doing.

We see that all the time with the States right now. There are best practices; you know, the LEAD program got talked about a little bit earlier, though we did not really get to talk about it. You see these all over the country right now, and some are very successful, and some are failures.

I was just out in California; one of the things I talked to them about is “You do not have to reinvent this wheel; we can tell you where the things are going to work and are not going to work.” It does not mean that they do that for every community, but these are the things that we all need to come together and we work on.

Ms. DEMINGS. You talked about fines having little impact on, say, drug manufacturers. What else do you believe could be done to ensure greater compliance?

Mr. PATTERSON. I think at some point we are going to have to hold these companies criminally accountable for some of their activities. And again, that is a tough balance to try and come to the right point on. Some are innocent mistakes, and generally we would never use an ISO on an innocent mistake. We want to work with the industry; we want to correct their behavior. But you see, it is not just in the drug distribution. You see it in banking; you see it in other places where civil fines just do not seem to catch anyone’s attention.

Ms. DEMINGS. And finally, with hiring and retention, any challenges in that particular area? I know you spoke earlier a little bit about it. But any particular challenges with hiring and retention?

Mr. PATTERSON. Yes. So, I think these are struggles that we have dealt with for a host of reasons in hiring and positions. Like I said, the good news is that we can lean heavily on our State and local partners as we try and catch up, but there is a lot of challenges in that space. Retention; people seem to still like coming to work for DEA, so we are doing a good job there.

Ms. DEMINGS. Thank you very much. Mr. Chairman, I yield back.

Mr. ROTHFUS. The gentlewoman yields back. We thank Director Patterson for his attendance at today’s hearing. That concludes our first panel, and we are going to invite our second panel to come up.

I would like to welcome our distinguished witnesses for a second panel. If you would please rise, and I can begin by swearing you in.

Do you swear that the testimony you are about to give is the truth, the whole, truth and nothing but the truth, so help you God? Let the record show that the witnesses answered in the affirmative. Thank you.

I would like to introduce the panel. Dr. Tim Westlake is a full-time emergency physician and is the emergency department director at Oconomowoc Memorial Hospital in Wisconsin. Among his

many collateral responsibilities, Dr. Westlake is the vice chairman of the Wisconsin State Medical Examining Board and executive committee member of the Wisconsin EPDMP design team and co-chairman of the Wisconsin State Coalition for Prescription Drug Abuse and Reduction.

Mr. Spencer Morgan is a Commonwealth's attorney for Accomack County, Virginia. Mr. Morgan started his professional career as a staff assistant in the office of our former colleague, Mr. Randy Forbes. Later, Mr. Morgan was a legislative assistant for the House Judiciary Committee Subcommittee on Crime, Terrorism, and Homeland Security. Welcome back.

Ms. Kristen Holman is the older sister of Garrett Holman. Garrett lost his life earlier last year to addiction. Ms. Holman has witnessed firsthand the devastation wrought by a destructive combination of drugs, including marijuana, ADHD medication, and synthetic opioids.

I would like to recognize my colleague, Mr. Cicilline of Rhode Island, to introduce our final witness on this panel, Dr. Josiah Rich.

Mr. CICILLINE. Thank you, Mr. Chairman. I appreciate the courtesy. It is a great honor for me to welcome Dr. Rich to the House Judiciary Committee. Dr. Rich is a professor of medicine at the Warren Alpert School of Medicine at Brown University and a practicing infectious disease specialist since 1994 at the Miriam Hospital Immunology Center, providing clinical care for over 22 years, and at the Rhode Island Department of Corrections, caring for prisoners with HIV infection and working on it in the correctional setting, doing research.

He has spent nearly a quarter of a century in public health and has been an extraordinary partner with local, State, and Federal Government in helping to develop good public policy. I have worked with him, and he has had the misfortune of being represented by me for 24 years in public life. But he was recently appointed by our Governor of Rhode Island, Governor Gina Raimondo, to the Overdose Prevention and Intervention Task Force expert team selected to advise the task force and formulate a strategic plan to address addictions and stop overdose in Rhode Island.

He is a cofounder of the nationwide Centers for AIDS Research Collaboration in HIV in Corrections Initiative and has served as an expert for the National Academy of Sciences, the Institute of Medicine, and many others; a real expert in issues of public health and addiction and the development of good public policy. And someone I have relied on for guidance over many years and really delighted that he will share his wisdom with this committee. I welcome Dr. Rich and thank you and yield back.

Mr. ROTHFUS. Your written statements will be entered into the record in their entirety, and we ask that you summarize, each of you, your testimony in 5 minutes. To help you stay within that time, there was a timing light on your table. When the light switches from green to yellow you have 1 minute to conclude your testimony; when the light turns red it signals your 5 minutes have expired. Dr. Westlake, you may begin. And if you could press the button so that your mic is on, please.

STATEMENTS OF TIMOTHY WESTLAKE, M.D., HARTLAND, WISCONSIN; J. SPENCER MORGAN III, COMMONWEALTH'S ATTORNEY, ACCOMACK COUNTY, VIRGINIA; KRISTEN HOLMAN, LYNCHBURG, VIRGINIA; AND JOSIAH RICH, M.D., PROVIDENCE, RHODE ISLAND

STATEMENT OF TIMOTHY WESTLAKE

Dr. WESTLAKE. Thank you. Chairman Rothfus, committee members, I appreciate the opportunity to talk to you today and for your leadership in addressing this issue. In my role on the Wisconsin Medical Examining and Controlled Substance boards I became the physician architect of the State's prescription opioid reform strategy and an expert on opioid scheduling. As an emergency physician on the front lines of the opioid battle field for the past 20 years, I have witnessed more tragedy than I care to recall.

Like you, I am laser-focused on what can be done to stop this senseless loss of life. It is why I am grateful for the opportunity to talk with you today and share a legislative solution that is actually working in Wisconsin right now. But first, a brief story about a young man named Archie Badura.

Every Sunday, we sat next to Archie and his family in church, where he was an altar server alongside my daughters. Archie got hooked on marijuana first, then prescription opioids pills; heroin followed shortly, and eventually fentanyl, a tragically all-too-familiar slide. The last time I saw Archie alive he was my patient in the ER. I had to resuscitate him with Narcan after he overdosed on fentanyl. Before discharging him, we pulled out a body bag, unzipped it, and pretended to fit him for it. It was a wakeup call.

Archie became serious about getting clean and started following recovery principles. He told his family he was going to beat the odds and not end up in a body bag. He stayed drug-free for 6 months after this. Sadly, he eventually relapsed on fentanyl and died at age 19. His mom, my friend Lauri, vividly remembers Archie being zipped up into a body bag identical to the one she had seen me showing him months earlier. In his honor, Lauri founded SOFA, Saving Others for Archie, and now helps others who are desperately trying to save their loved ones.

It is incontrovertible that the increased availability of prescription opioids has fueled the opioid epidemic. As a medical regulator, I have spent countless hours working to identify and implement best practices. For starters, we need more judicious prescribing practices. We are doing that in Wisconsin, not with top-down mandates but through education and partnerships within the medical community. In my written testimony I provide more detail about the cutting-edge prescription drug monitoring program reforms and educational reforms that we have put into place.

The fact is that the lion's share of medical regulation does and should occur at the State medical licensing board and health system levels. Where Congress can and has and can continue to be helpful is in law enforcement and in providing flexible funding to the States themselves to invest in communities where the dollars are most needed. When government intervenes too much, for example, with the development of the pain scale and pain as the fifth vital sign, there is too much room for unintended consequences.

By far, the deadliest front in the opioid war is the danger posed by creation of fentanyl-related substances. These deaths now surpass heroin deaths. The lethal dose of fentanyl is two milligrams, which means that there could be enough fentanyl, if this box were filled with fentanyl, that it would kill 900,000 people, which would be more than the entire population of Washington, D.C.

Fentanyl variations and related substances are so deadly that they can be used and are actually classified as chemical weapons. They are not just drugs. They are actually considered weapons of mass destruction. The bad guys use loopholes in the existing scheduling laws to create new legal fentanyl variants. These untested chemicals are then produced mostly in China and introduced into the opioid supply.

As our prescription opioid reforms take effect and the medical community returns to more judicious decision prescribing practices, the market for counterfeit pills continues to explode. Most illicit opioid users have no idea what they are consuming. With the advent of counterfeit pill production, they believe they are ingesting a safe, trade-name manufactured pill, when actually it is a fentanyl-related counterfeit substance. These pills can be alarmingly more strong than what they are purported to be, up to hundreds of times stronger.

The singer Prince died from a counterfeit Vicodin pill ingestion that he thought it was Vicodin; it was actually Fentanyl. During 2016, in one weekend there were 12 deaths in Milwaukee from counterfeit pills that contain cyclopropyl fentanyl, which at that time was legal and was shipped in on the Internet.

We saw this coming in Wisconsin, years ago. We worked closely with the DEA to get ahead of it. We created an enacting, novel scheduling language now being modeled nationally, X60 or the SOFA Act, Stopping Overdose of Fentanyl Analogues in homage to Saving Others for Archie. It controls by structure all likely and possible bioactive chemical fentanyl modifications. The novel catch-all legislative language allows us to schedule proactively and not wait for loved ones to die before we can schedule each new modified fentanyl variant. So, instead of playing whack-a-mole with the variants as people die and we discover them, it unplugs the entire fentanyl machine.

The week after Wisconsin enacted SOFA, DEA published the identical scheduling language in the Federal Register as the method of Federal temporary scheduling. Chemists around the world and in China must be paying attention, because since that announcement 6 months ago, there have been no new fentanyl variants found.

In the previous 2 years, there were 17 that were found and scheduled, which represented hundreds of deaths. But the language needs to be written into the U.S. code, as the DEA administrator said, for the best permanent scheduling solutions. Many thanks to Mr. Sensenbrenner and Senator Ron Johnson who have the Federal SOFA Act, and thank you for their leadership on that.

When asked how often I see fentanyl overdoses, the answer is tragically far too often. The last shift I worked was 2 days ago on Sunday, and I was preparing my testimony, and I was interrupted to go resuscitate a fentanyl overdose. It is for this reason that I

urge you to pass the legislation and make it so. Thank you for your time and consideration, and I look forward to answering any questions.

Mr. ROTHFUS. Thank you, Dr. Westlake. Mr. Morgan, you are recognized for 5 minutes.

STATEMENT OF J. SPENCER MORGAN III

Mr. MORGAN. Thank you, Mr. Chairman, ranking member, and members of the committee: thank you for inviting me to testify on this important topic. I intend to address several issues concerning opioid addiction and the increased amounts of heroin and fentanyl from the perspective of a local prosecutor. Simply put, in the words of the Worcester County drug task force coordinator—or the equivalent of the criminal enforcement team there—there has never been a more dangerous time to purchase illicit drugs.

Little bit about Accomack County, we are at the southern tip of the Delmarva Peninsula. Accomack is a unique mixture of agriculture, tourism, and aerospace in industry through Wallops Island space port. Current population is right around 32,000 people.

When I first arrived in Accomack County in the fall of 2011 after graduating law school and taking the bar, opioids and heroine had really yet to make a huge widespread public impact on the county. Arrests were generally low, and we were aware of prescription medication abuse. However, the full extent of the problem had not been revealed.

At the same time, I did learn Worcester County, Somerset County, they were beginning to experience significant amounts of heroine at that time. In Accomack, the harbinger of what was just below the surface really became the widespread abuse of buprenorphine, or Subutex as the brand name is.

The drug used in the treatment, generally where the addict is treated with, in conjunction with drug treatment and counseling, and then titrated off the drug, which helps them manage the symptoms of opioid addiction became a currency among addicts for maintaining their addiction and trading for more powerful narcotics.

Once we began to see this, it was not long before we were seeing the substance attempted to be smuggled into our jails. And then, prosecuting those offenses and ultimately, and ironically, I ended up prosecuting someone involved in such a scheme for cleaning up the scene of an overdose death, where her boyfriend was found unresponsive, and police responded, EMTs responded, and she went back in while they were trying to save his life and hid away, or secreted away the signs of the heroin abuse.

I will note, however, that recently with the advents of Suboxone, a substance which contains naloxone, the inhibitor to prevent opioid interaction. We have seen decreased abuse of Suboxone, but by then, we were learning that we had dealers at the northern end of our county, who when they would serve clients with cocaine, they were providing gratis a bag of heroin and suggesting that the addicts return back when they wanted more of that.

Some of the challenges we have seen, not the least of which are the deadly nature of this substance, the substance fentanyl and carfentanil substances, carfentanil, fentanyl, certainly are deadly.

And one of the most tragic things I have experienced is the death of defendants and witnesses beyond availability of those people before we have a chance to go to even trial, or offer any of them any programs through the justice system that we have in Virginia for those addicts.

Some of these substances are so deadly, as Dr. Westlake has testified, that we have stopped field testing narcotics in Accomack County for fear of officer safety. The problem with our field testing is that if an officer were to come into contact with those substances, they could potentially overdose on the scene.

My time is running low, but I will say that there has been substantial headway in Accomack County. We currently are enjoying a level of cooperation between the medical treatment providers, substance abuse counselors and law enforcement than I think has ever been seen before. We have produced informational packets, which we supply our officers who can give addicts, be it a defendant or a suspect, a witness or a victim to crime in order to help get as many people in to substance abuse treatment and recovery as possible. We see it as a public health threat, where law enforcement can certainly partner with treatment providers and I will yield back the rest of my time, and happy to answer any questions.

Mr. ROTHFUS. Thank you, Mr. Morgan. The chair recognizes Ms. Holman, for your opening statement. Five minutes.

STATEMENT OF KRISTEN HOLMAN

Ms. HOLMAN. Thank you. February 17th, 1996 was one of the best days of my life. My parents brought home the baby brother I had been asking for since I was able to speak. My little brother Garret grew to be one huge hardy kid, who always had the room laughing. His smile was contagious, and he always demanded everyone's attention.

We grew up in Forest, Virginia, and we had the best childhood. We were always outside, making up games, riding four wheelers, and meeting with friends throughout our neighborhood. Garret cared so deeply for everyone he loved. My brother had a bigger personality than words can describe. My brother would be the first one to stick up for someone, and he would be the first to stand out in a crowd.

Garret was diagnosed with ADHD very early in life. He was a hyper kid. He consumed everyone's energy at all times. When he became of age to make the decision to get off his medications for ADHD, he began to self-medicate. It started with marijuana.

With marijuana, Garret was able to self-medicate his condition on his own terms. He was able to function without feeling like he was forced to take a prescription medicine. He realized that this alternative would not work when he went to get a job, and realized he would be drug tested for any job he applied to. This is when he turned to more dangerous alternatives that did not show up on a drug test at the time.

There was no explaining to him the dangers of quitting these prescription meds so abruptly, and there was nothing that we could say or do that he wanted to hear. We were just forced to watch him choose this path while hoping and praying he would see the light and reach out to accept our help.

I watched my brother change from an amazing heartfelt, selfless person to someone I did not recognize. There was a darkness in his eyes, and an overall loss of life and love. Not only did I watch my brother change, I watched my parents and then myself slowly fade into that same dark place. The inability to help him made us all feel like we were not doing enough, when in reality, we became so heavily involved in him that we all lost ourselves. We lived life never knowing where we would get that one phone call that no one wants to hear.

As a sibling, I played referee between my mom and my dad, my parents and my brother, while often being angry at one or all of them, just because none of us had the answer. Addiction is a subject that many feel ashamed to speak of, and because of this feeling, we were left to suffer alone. Close family and friends knew of Garret's addiction, but no one but the four of us knew the true extent of it. Small talk and even such that should be fine became hard, and having conversations with people to worry my brother what he was constantly doing, and if I would see him again became the only thing I truly cared about.

Living in fear of losing my brother every day played a major stress role in my life, and I constantly dropped everything to be wherever I needed to be for Garret and my family. I spent hours and hours trying to talk to him, and trying to let him see how much love we all had for him. Garret was angry with himself over his addiction. He wanted to be happy and he could not. He tried so hard, and when he lashed out at us, it made it that much more hard for him.

In December of 2016, I received the news that my brother had overdosed. My dad revived him, and he was sent to the hospital. I remember getting that news and dropping everything and rushing to the car. When he finally woke up and we told him how lucky he was that he was still alive, he did not even blink. He was not thankful. He was not relieved. And that was because he was already gone. My little brother was not the person looking back at me anymore, and I did not recognize this person. And I could not understand why he was not hugging us and crying tears of excitement over getting a second chance at life.

My family knew we needed to do something drastic. We needed outside help. Our normal interventions were no longer buying us time with my brother. We needed a solution and an action plan. My parents forced him into a mental health evaluation, which he was only required to stay at for 5 days. After the 5 days, he reluctantly went to a 30-day in-house treatment program.

One week after he was released, my dad found him overdosed again, and revived once more. My dad forced a second evaluation, but the judge released him on February 6th, 2017. I lost my little brother and only sibling on February 9th, 2017 to a synthetic opioid that was delivered straight to him in the mail from China.

I cannot explain why this happened to my brother, and I do not know how to fix it. And I do not know what my family could have done differently. What I do know is that the drug addiction did not just take the life of my brother, but it took a big piece of my family's life. There are empty silences in conversations where he

should be present. And there is a fight in all of us that still does not want to give up, and I do not believe it ever will.

Garret was not just a good person, he was a great person who fell into a terrible trap that none of us could get him out of. But we tried and tried and tried. My family feels that we failed Garret, but the truth is, this is something that millions and millions of families are dealing with. And people feel ashamed. And they do not want to speak out about what is going on. And that just leads people to suffer in silence.

Although it is too late for Garret, he is in my heart and head every day, and it only feels right for him to reach people at a national level. I cannot be any more inspired at this point to do whatever I can to reach out to families like mine. Thank you.

Mr. ROTHFUS. That was incredibly courageous. Garret would be proud of you. Thank you. The chair recognizes Dr. Rich for 5 minutes for his opening statement.

STATEMENT OF JOSIAH RICH

Dr. RICH. Thank you. It is a tremendous honor to be here and I want to thank Ms. Holman for such a courageous testimony. I have spent 25 years caring for people both in the community and behind bars. And, when I first went behind bars, it was to take care of people with HIV. And now, I found myself mostly taking of people with opiate use disorder. This rapidly evolving deadly epidemic demands a sustained public health approach, similar to the Ryan White CARE Act for the AIDS epidemic.

Opioid addiction is highly stigmatized, poorly understood by most people, and it is characterized by ongoing use despite negative consequences. Now, opiates are different than other addictive substances by two physiological properties, tolerance and withdrawal. Tolerance means you need an ever-increasing dose to get the same effect. And withdrawal is extremely painful when you abruptly stop opiates. You literally feel like you are dying.

So, this disease wraps around you like a boa constrictor. Every time you breathe out, it tightens, so when you try and breath in, you cannot. That results in changes in the brain chemistry and the brain pathways, and your response to stimuli. And it feels like you need opiates for your very survival. Just like you need to breath, you need to drink, you need to eat. So, people get desperate, because their ongoing use increases. They resort mostly to stealing, getting involved in the sec trade, getting involved in the drug trade.

So, what can we do about this? Our punitive approach has clearly failed. And, you would predict that from knowledge of the disease. So, treatment. Now, when we talk about treatment, you hear people talk about a treatment bed, a detox, and frankly, that does not work. That is an antiquated approach based on a drug-free model. And, 90 percent of the time, people relapse. And relapsing today, in the age of fentanyl contamination of our opiate supply is far more dangerous and results in death.

So, treatment that we have now that is effective, the best treatment we have is medications for addiction treatment, MAT. We have three FDA medications that when taken, they block the high of opiates and they block the withdrawal. And these are the two

main drivers of ongoing use. They stabilize people lives, and allow them to work on their recovery.

In Baltimore, when they ramped up MAT, they drove overdose tests down 80 percent, similar results in France, and in Rhode Island, we rolled out MAT in our corrections department, our prison and jail, and we drove within year overdose deaths and people released from incarceration, we drove them down 60 percent. So, this is the proof of the concept, that MAT is what we need.

We also need for those who are unable or unwilling to get into MAT to outreach to them, to engage them, to give them the tools and the education they need to reduce their risks, including the lock zone and drug checking. There also have been many examples of public health and public safety collaborations, include Good Samaritan laws, offering the lock zone to first responders who, police and fire. We heard about a lead program in Rhode Island. We have safe stations, where the fire stations act to engage people and get them into care.

But, the punitive approach will disproportionately affect those most disadvantaged. And we hopefully have learned from our punitive approach to the crack epidemic, how it lead to mass incarceration of predominantly minority individuals.

So, the punitive approach will distract attention and resources away from what is clearly needed, which is a strong and sustained public health approach. Thank you.

Mr. ROTHFUS. Thank you, Dr. Rich. The chair recognizes the gentleman from Pennsylvania, Mr. Marino, for 5 minutes.

Mr. MARINO. Thank you, chairman. Appreciate it. Thank you for being here. I apologize for you having to be the second group that has to wait, but I want to pose a concept that I have had. I was a prosecutor for 18 years. I was a district attorney in Pennsylvania, and I was a US attorney with the Bush administration.

And, first of all, I will still stick to the fact that dealers, major dealers, need to be locked up. Period. People toting guns and shoving guns in people's side and drug deals need to be locked up. So, with that said, I have a concept, and I know that quite often, a person addicted to drugs will do some deliveries or dealing to get money to supply their habit. That is just all part of it. I do not necessarily, unless they are violent, want to see those people going to prison.

And, my concept is this opioid addiction is so much more worse than the cocaine and the crack cocaine, particularly because of the fentanyl. I want to see, and I tried to do this 2 years ago, and Karen Bass, a good friend of mine, on the other side, we are looking into this again. I want to see mandatory inpatient treatment. When a parent sees something going on with their child, or when a child sees something going on with their parent, we need a system, a central system where that person can call and ask for help, because it is the toughest thing to do. It is where do I go for help? So, we have to have some central location that can get those people, that person, or that family directly to someone who can help them in their area.

And, we have many hospitals across the country. We have good outpatient treatment facilities. But, to get off the opioids, to get off of heroin, that is going to take inpatient treatment, and it is going

to take a long time. And what I think we should do is first of all make it into have that family member have the ability to go before the court and have an expert testify position that yes, this person is addicted to this. And this person needs inpatient treatment.

They cannot leave. It is going to be a lockdown situation. But in addition to the health needs, the mental health needs, we need to start working on the family as a whole, educating these people. Starting from pulling the bootstraps up. And then, the group will make a determination in that particular hospital as to when this person can have furlough, when they can get out, what we do when they get out. Just do not say, "You are out on the street now."

And, it is going to be, I think, one of the only ways in addition to going after the bad doctors, pharmacists, pharmaceutical companies and making them pay as well, one way, and/or another. So, what say you? So, you could start Dr. Rich, and go down the line.

Dr. RICH. Sure. Well, lot of material there to work. I agree with a number of things you said. I think the need for health and treatment and mental healthcare in addressing the family, and giving people real opportunities to get a better life, and that is really a big part of recovery.

You mentioned that we have treatment all over the country, and we have a need of inpatient. I would say we do not have treatment all over the country. We have a very fragmented system, and a lot of it is based on faulty thinking, the notion that you can get someone to a place, a bed, and that something magical is going to happen, and then they are going to come out. So, that does not work.

We do not require the inpatients most of the time. I would say that what we need to do is offer effective treatments that are proven. And most of the time that is not inpatient. Now, there are some cases where, you know, that is being explored in Massachusetts, for example they have—they are mandating people into treatment, exactly what you said. But instead of treatment programs, they have used an old jail. They have in jail cells.

Mr. MARINO. No, you see, mine, mine is——

Dr. RICH. And they are not getting medications.

Mr. MARINO. Mine is a hospital.

Dr. RICH. Right. Yep.

Mr. MARINO. With experts making that determination, and I see, and almost——

Dr. RICH. So, I think we can learn a lot from the Portuguese example, where that is exactly what they did. They did not mandate it. They made it available, made it realistic. That is how the rest of——

Mr. MARINO. But in my 18 years, I have never heard a person addicted to drugs not say to me, "I can get off any time I want."

Dr. RICH. Well, they say different things to me.

Mr. ROTHFUS. The gentlemen's time has expired. The chair recognizes the gentleman from Rhode Island, Mr. Cicilline for 5 minutes.

Mr. CICILLINE. Thank you, and thank you to all of our witnesses, Ms. Holman. Thank you for being here. I know your brother is looking down on you very proudly for your courage. So, sadly, I have had many friends who have lost loved ones and children to this same disease. And, we all need to be reminded that is why we are here, and we need to come up with some answers.

Dr. Rich, I want to just focus a minute on what you just described. You know, I think a lot of folks, particularly families that are struggling with a loved one who has an addiction, the idea of getting them into a treatment facility, where they can have the peace of mind to know they are safe, seems like, sort of, you know, a natural inclination.

But it turns out, according to your testimony, that, while that may provide you peace of mind, it is actually not the best strategy in most cases for really addressing the addiction. And you, the work that you have done on what on the medically assisted treatment seems to be much more successful.

So, I am wondering if you could talk a little bit, in the face of that data, is it just old thinking? Why is that we continue to hear people talk about we need more beds, there has to be more placements. Is it just this reluctance on the using medicine, or what?

Dr. RICH. The medications are limited. You know, they are not perfect for everybody. They have a lot of side effects. They have a lot of problems. But they are the best thing we have.

The problem with the going to a detox is just as tolerance goes up very quickly, tolerance also goes down very quickly. And so, when you let people out of a detox, as we heard when Garret was released, he overdosed right away. Now, probably if he had been using up until that point that he took that dose, he would have had a much higher tolerance, and would not have overdosed right then and there.

So, we are setting people up for overdose by putting them through detox. And, they might not have detoxed 10 years ago, 5 years ago when we did not have fentanyl. But now we have fentanyl, and it is far too dangerous. So, you know, this is rapidly evolving. So, we really need to get with the times and get people on to these medications.

Now, there are some cases where, you know, maybe if the medication was tried and there is absolutely nothing else we can do, then maybe we need to be more of a big brother and be more controlling. But, we have already shown that by giving people access to, and continuing them on treatment, that they are going to reduce their overdose deaths. We need to roll that out right away.

Mr. CICILLINE. And that is the work that you have done in the prison with success. I think you said 61 percent success rate.

Dr. RICH. Sixty-one percent drop in overdose deaths within a year of starting that program, and people coming out of corrections. But, that does not have to be corrections. People should not have to go be incarceration—

Mr. CICILLINE. That was my impression.

Dr. RICH [continuing]. In order to get treatment. We can do that in pretrial arrest. We can do that in the hospitals, in the emergency rooms, in the clinics. We just need to roll it out. We need high quality programs that not only give the medications, we are really working on recovery work on the mental health work, all the other things that the congressman was talking about.

Mr. CICILLINE. And what do you think we can do? What can Congress do? I mean obviously, you know, providing resources so medically assistive treatment is available. Are there other things we can be doing in terms of closer regulation of prescriber activities? Bet-

ter coordination through pharmacies? How much of that issue do you think is contributing to this real growth in opioid overdoses?

Dr. RICH. We have a whole population that is addicted now. And that started with the overprescribing. But they are there. And we can shut down the prescriptions. Some of them are going to say, "Oh, I guess I did not need that." But, most of them are going to go, at least for a time, and find out whatever they can find. So, that is very dangerous.

We also have people that have not started taking opiates. And we need to do whatever we can to prevent them from starting. And a big part of that is education, understanding what is going on.

Mr. CICILLINE. And finally, I know you have been part of the work that Governor Raimondo has been leading in Rhode Island that I think is really a model in terms of bringing all of the stakeholders and affected parties together to really develop a strategy and a plan. Maybe you could spend the last few minutes just talking about that.

Dr. RICH. Well, I was fortunate to be involved in that. The governor, instead of having a stakeholder process, had an expert driven process where they had experts making decisions rather than stakeholders saying, you know, fund my program. And that led to really looking at the evidence, getting a lot of information from the community and from the stakeholders, and developing a plan. We had a simple four-point plan expanding treatment, and 20,000 out of our population of a million were people that needed to be onto MAT.

And so, identifying where those people interact with systems and shutting them over into treatment. So, we have started to roll that out, and we think we can—we need to continue it, double down on that strategy.

Mr. CICILLINE. Thank you, Dr. Rich.

Mr. ROTHFUS. The gentleman's time has expired. The chair recognizes the gentleman from Louisiana, Mr. Johnson, for 3 minutes.

Mr. JOHNSON of Louisiana. Thank you, Mr. Chairman. We will be very brief. The bells mean that our votes have been called. So, we are all sort of, do not want to miss a vote. We are going to race out, so you will be just a few more minutes. I do not want there to be a perception today that what you have said here for the record is not important, just because we do not have a quorum. It is a busy day on the Hill. You know how this goes. But, your record is important to us. Everyone will review it. Your time is well spent here, and we greatly appreciate all of you, especially your personal tragedy. It makes a difference, it does.

Real quick practical question, and maybe this for Dr. Rich or Mr. Morgan. We referenced today buprenorphine, and I am just a constitutional law attorney. I do not know much about all this. But, my understanding is buprenorphine is one of the medications that is used to wean people off of opioids, is that right? It is not an opioid itself, right?

Dr. RICH. It is an opioid.

Mr. JOHNSON of Louisiana. Okay.

Dr. RICH. And it is what we called a mixed agonist. So, it partly turns on the receptor at low doses, and it also blocks you from getting high, and blocks you from going into withdraw.

Mr. JOHNSON of Louisiana. So, because of the blocking agent, it is one of the effective means to try to take people down off of their addiction?

Dr. RICH. Well, so, you know, a lot of people say, "Well, if I start on these medicines"—methadone, buprenorphine, commonly known as Suboxone, or deep on naltrexone, the vivitrol injection—"if I start this, how long do I have to stay on it?" And the answer is, for many people, a very long time. You need to stay on as long as you need to stay on. But, I think that the concept that somebody could be put on those medicines and weaned off in a short amount of time, and then they are going to be fine, this does not work that way.

Mr. JOHNSON of Louisiana. And so, what I am hearing, in my district back home, I have talked to a couple of pain management physicians. And they are feeling pressure from the insurance companies, because of perhaps what may be an overreaction to all this, to impose access limits or quantity limits on those who are appropriately using buprenorphine, or one of those derivatives. How do we separate those issues so that those patients are not adversely affected and caught up into the wave of those who have real addiction?

Dr. RICH. Buprenorphine, because of its properties, is the safest opioid to use. I find it is very effective for a lot of people with chronic pain. So, the insurance companies are reluctant to allow that, because there is a much bigger market of people with chronic pain. And it is an expensive medication. I routinely get letters saying, "Oh, well, have you tried oxytocin or, you know, oxycodone, or, others."

Mr. JOHNSON of Louisiana. I have people in my district, the insurance company said, "Why do you not go get on oxytocin?" Because they do not want to pay for buprenorphine anymore.

Dr. RICH. Exactly. But, we need to roll that out. There was mention of buprenorphine being a diverted substance. When we have studied people and asked them, "You know, have you gotten diverted buprenorphine?" They said, "Yes." And then we asked them, "Well, what did you use it for?" And they used it to treat these withdrawal symptoms. So, they are not using it to get high.

They are not going out to party with it. They are trying to treat themselves. They are using it as it is really indicated. But they cannot get access to it from their physicians, because there are not enough prescribers. So, they end up having to get it illicitly.

Mr. JOHNSON of Louisiana. I am way out of time, but I would love to talk with either or both of you later about mechanisms we can use for Congress to step in and help make that distinction for the people that really need it.

Dr. RICH. Sure.

Mr. JOHNSON of Louisiana. So, thanks for your time.

Mr. ROTHFUS. The chairman yields back. The chair recognizes himself for 3 minutes, if I can try to get a couple questions in before we have to run off for vote. So really, thank you everybody for participating in this very informative panel for us.

Mr. Morgan, your testimony referenced the synthetic drugs like fentanyl, especially their lethality. I especially represent a district

in western Pennsylvania that has become an epicenter for synthetic opioid trafficking and usage.

One issue I hear about from other prosecutors are concerns dealing with forensic analysis, of blood toxicology and overdose death cases. Many times, the medical examiner reports list multiple controlled substances on the certificate's analysis, and this makes determining the precise cause of death difficult, as to which substance was responsible, or whether it was a combination of multiple substances. Have you encountered this problem regarding overdose cases in your jurisdiction?

Mr. MORGAN. We have not encountered that problem specifically. I am aware that it is a problem, when we get a certificate or a toxicology report from an ME's report that says there are these multiple amounts. The toxicologists in our certificate, as I understand it, will try and put that percentage by percentage into an equation or an amount in the blood, which is representative of the proportion of that sustenance.

Mr. ROTHFUS. Is proving causation a challenge in that context?

Mr. MORGAN. Yes. Proving causation, I imagine, would be a challenge. The quickest way I would combat that is I would get on the phone with my toxicologist within Virginia, the Department of Forensic Science, and speak with them. And look for an expert opinion to be tendered, ultimately a trial that says that this amount of fentanyl or this percent of fentanyl would be a cause of death or could be a cause of death.

But, in my experience, I think if I see fentanyl, it is going to be usually mixed with heroin. So, between fentanyl and heroin, I think I have good grounds to say beyond a reasonable doubt that this would be the cause of death. But I would need a toxicologist there, and that has presented problems in the past due to the volume of these types of cases around the State.

Mr. ROTHFUS. Dr. Westlake, you talked a little bit about some voluntary, as opposed to mandated—I think it is the context of prescription guidelines. I mean, part of the Comprehensive Addiction Recovery was to have Federal agencies take a look at this issue. I mean, can that help to establish some kind of standard of care, so that physicians at least can be aware of what would read a range of normal?

Dr. WESTLAKE. Yeah, I mean, I think that has already happened. I think with the release of the CDC guidelines, and then a lot of different States, in Wisconsin, for example, we had the State law passed that would promulgate guidelines from the medical examining board. And I think that is a key factor is that what I alluded to in my testimony was that we want the intervention into medicine to be from medicine itself and not from the legislature. I mean, if we look at the cause of the pain scale, pain crisis, opioid crisis to begin with, a lot of it came out the pain scale.

And so, I think we got to be really careful about interventions. But they are definitely necessary. And I think those educational interventions are already happening. And the CDC guidelines kind of lead the front of that. And I think education is happening. And we will see the results a couple years from now.

Mr. ROTHFUS. Ms. Holman, you know, what kind of options were presented for your brother when subjected to treatment?

Ms. HOLMAN. I mean, when we were seeking treatment?

Mr. ROTHFUS. Right.

Ms. HOLMAN. It was really hard to get anything, honestly. He got himself into trouble with law enforcement, so, he spent time in jail, and it seemed like it was easier to get him there than any kind of treatment.

Mr. ROTHFUS. You know, I really appreciate you being here. Your being here is going to help other families.

Ms. HOLMAN. I hope so.

Mr. ROTHFUS. So, I really encourage you to continue the work you are doing with your family.

Ms. HOLMAN. Thank you.

Mr. ROTHFUS. And know that you are not alone. And I think Dr. Rich talked about the stigma that has been out there, but I think your being here is going to help address that issue and help other folks find treatment. Dr. Rich, I appreciate where you are coming from, with respect to the punitive nature of what we have talked about, but do you draw any distinction at all between the user and the pusher?

Dr. RICH. Sure.

Mr. ROTHFUS. I look at this thing as a prevention enforcement treatment, prevention, enforcement, treatment. All three are important. And when you have people who come into or join this network of distribution, of this poison, that is responsible for the deaths of 10s of thousands of people in this country, you know, I want to go after those folks who are pushing this poison.

Dr. RICH. It is impossible to hear the tragedy that Ms. Holman described and not be angry about it. And, I share that anger. And people that are profiting from it, you know, it is a human response to want to punish them. We have tried that for 30 years, and the result is a disaster.

So, you know, I think we are going to get a much better result. Now, that does not mean I think we should legalize. I think we should try and clamp down as much as we can. But, if you have mandatory minimums, and you are sending 40-year-old mothers to——

Mr. ROTHFUS. I think you can look at things like that. But again, the premise being if you are pushing poison in our communities, you are going to be held accountable with that. I am sorry, I have to go and vote. We are almost out of time. But I do want to thank everybody for coming in today.

This concludes today's hearing. Thank you to our distinguished witnesses for attending. Without objection, all members will have 5 legislative days to submit additional written questions for the witnesses or additional materials for the record. The hearing is adjourned.

[Whereupon, at 1:26 p.m., the hearing was adjourned.]