OFFICE OF NATIONAL DRUG CONTROL POLICY: REAUTHORIZATION

HEARING

BEFORE THE

SUBCOMMITTEE ON
GOVERNMENT OPERATIONS

OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
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OFFICE OF NATIONAL DRUG CONTROL POLICY: REAUTHORIZATION

Wednesday, December 2, 2015

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

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2154, Rayburn House Office Building, Hon. Mark Meadows [chairman of the subcommittee] presiding.

Present: Representatives Meadows, Jordan, Walberg, Gowdy, Mulvaney, Buck, Carter, Grothman, Connolly, Maloney, Norton, Clay, Plaskett, and Lynch.

Also Present: Representatives Chaffetz, Turner, and Cummings.

Mr. MEADOWS. The Subcommittee on Government Operations will come to order. And without objection, the chair is authorized to declare a recess at any time.

The Office of National Drug Control Policy, or the ONDCP, is charged with guiding the big picture strategy for addressing illicit drug problems here in this country and the consequences thereof. I think we can all agree that this is a problem that merits meaningful solutions. And over the years, we as a Nation have tried a variety of approaches to address the illicit drug problem. From its launch in 1988 to the last reauthorization in 2006, and still today, the ONDCP has been intimately involved in the spectrum of drug control efforts.

Today's hearing will take a look at the ONDCP, particularly since its last reauthorization, which expired at the end of fiscal year 2010. There are important questions for consideration. One, has the ONDCP evolved to match the evolution in our Nation's drug control strategies? Two, what is the value of this office and is it correctly placed and appropriately resourced to fulfill those functions?

And earlier this year, the agency actually sent a letter to Chairman Chaffetz and Ranking Member Cummings and their counterparts in the Senate, and the letter included proposed language for reauthorization of the ONDCP, and today's hearing will focus also and discuss that proposal.

We will also hear testimony from the Director of National Drug Control Policy, Mr. Botticelli, who will speak knowledgeably to the work that is being done there as well as the proposed authorization language. And as we look at this, these proposed changes to the authorization of the High Intensity Drug Trafficking Areas program, referred to as the HIDTA program, now, the HIDTA program has

been a leader in bringing together local, State, national, and tribal law enforcement entities to reduce the supply of illegal drugs by targeting and disrupting drug-trafficking organizations. I might note that in that particular area, we are very familiar with that with local law enforcement in western North Carolina, as we have one of those areas that has that cooperation.

The ONDCP changes would allow for the use of the HIDTA funds for engaging in prevention and treatment efforts. Previously, only limited HIDTA funds would be used for prevention efforts and no funds were permitted for treatment. So in response to this proposal, the National HIDTA Directors Association wrote to members of the Oversight Committee suggesting a compromise that would allow for the use of funds for prevention and treatment, but with a cap. I imagine that the congressional liaison for the National HIDTA Directors Association, Mr. Kelley, will be able to provide further explanation on that letter and the proposed language.

And so we look forward to hearing from you and all the witnesses today. And I would now recognize Mr. Connolly, the ranking member of the Subcommittee on Government Operations, for his opening statement.

Mr. CONNOLLY. Thank you, Mr. Meadows. Thank you, Mr. Chairman, and thank you for holding this hearing, a very important topic.

The Office of National Drug Control Policy plays a critical role in coordinating the Federal response to our troubling drug epidemic, in which the annual deaths from drug overdoses now outnumber those caused by gunshots or car accidents. The Office itself manages a budget of $375 million, with two national grant programs, and coordinates the related activities of 39 Federal departments, agencies, and programs, totaling more than $26 billion.

So it's more than a little concerning that Congress allowed the Office's formal authorization to expire 5 years ago, allowing it simply to subside on annual appropriations rather than a long-term authorization. It's been nearly a decade since Congress seriously considered our national drug control policies and activities, and as we'll hear from today's panel, a great deal has changed in that interim period—sadly, not for the better.

Mr. Kelley of the National HIDTA—High Intensity Drug Trafficking Areas program—Directors Association, aptly notes in his remarks that the scourge of drug abuse has no boundaries, it does not recognize geography, social, economic status, race, gender, or age. The efforts of the ONDCP are vital to and visible in each of our respective communities. So, Mr. Chairman, I appreciate the bipartisan spirit with which we've approached this hearing on the ONDCP's performance and its proposal for reauthorization.

I know many of us are troubled, very troubled, by the spike in heroin use in our communities. Heroin used to be actually a very static demand drug. No longer. In my home State of Virginia, for example, the number of people who died using heroin or other opiates is on track to climb for the third straight year. Heroin-related deaths doubled in my own home county of Fairfax, just across the river, between 2013 and 2014, and that follows a troubling trend all across the national capital region. And I know Eleanor Holmes Norton shares that concern as well.

Communities in my district have been fortunate to receive assistance from both the High Intensity Drug Trafficking Area program, which provides grants to local, State, and tribal law enforcement agencies to counter drug trafficking activities, and the Drug-Free Communities Program, which provides grants to create community partnerships aimed at reducing substance abuse, especially among young people. Virginia now has 20 counties out of 95 that have been designated as High Intensity Drug Trafficking Areas. Four are part of the larger Appalachian region HIDTA and 16 are part of the Washington-Baltimore area HIDTA.

While the HIDTA program has historically been more enforcement focused, we're beginning to see an increased emphasis on prevention and treatment, and I think that's appropriate. That's reflected in the administration's reauthorization proposal.

Current law caps at 5 percent the amount of funds that can be used for prevention activities—5 percent. Twenty-seven of the 28 designated regional High Intensity Drug Trafficking Areas support prevention activities. The statute actually prohibits funds from being used for treatment programs, with the exception of two grandfathered programs in the Washington-Baltimore and Northwest regions, as their efforts predate the prohibition in the previous authorization.

In fact, my district benefits from that particular exception, with Fairfax County receiving a subgrant to fund one full-time position—one—providing residential day treatment and medical detoxification services.

I think that 5 percent limit does not make sense, especially in light of a lot of changes in the demand for opiates and other drugs.

I look forward to hearing more from Director Botticelli about the shift to public health-based services within the National Drug Control Strategy. The administration's proposed reauthorization language would allow the regional drug trafficking areas, upon request of their boards, to spend funding on treatment efforts and to spend above the current cap on prevention efforts. That would amount to a considerable investment in strategies such as diversion or alternative sentencing and community reentry programs that have proven successful here in the national capital region and other communities across the country.

I appreciate, Mr. Kelley, with your law enforcement background, acknowledging that we cannot arrest our way out of this problem and that we're moving more and more to a partnership between public safety and public health to create a more holistic approach to the substance abuse challenges facing so many communities across America. Director Botticelli's compelling personal story speaks to the power of treatment and recovery.

Mr. Chairman, I hope our subcommittee can play a constructive role in helping to advance this important reauthorization effort, and I very much appreciate the bipartisan spirit with which you and our colleagues have approached it. I look forward to hearing the testimony this morning. Thank you.

Mr. MEADOWS. I thank the gentleman.

The chair now recognizes the gentleman from Maryland, the ranking member of the full committee, Mr. Cummings, for his opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. And as I listened to Mr. Connolly, I could not help but be reminded, in this day and age we are fully realizing that drug addiction has no boundaries—has no boundaries. It affects blacks, whites, rich, poor, from one coast to the other of this United States. And his statements, that is Mr. Connolly's statements with regard to treatment, ladies and gentlemen, some of the most profound words that will be spoken here is we better wake up and begin to address this more and more as a health problem, because, again, what we're seeing now with heroin, I've known about heroin for many, many years in Baltimore. But now it's spreading everywhere and now people are beginning to understand that prevention is so very, very crucial.

And so the Office of National Drug Control Policy, or ONDCP, has a difficult but crucial mission. It is tasked with leading efforts across the Federal agencies to reduce drug use and mitigate its consequences. ONDCP is also responsible for developing and implementing strategies and budgets annually while also furthering long-term goals. Although none of these responsibilities are simple, I have been impressed with how diligently this administration has tackled these tasks while being efficient with the resources that are provided.

We're here today to discuss the reauthorization of this Office's vital work, which includes the Drug-Free Communities Program, which I'm very familiar with, a valuable grant program that mobilizes our communities to prevent youth drug use. It also includes the High Intensity Drug Trafficking Areas, or HIDTA, program, which operates through regional efforts with State, local, and tribal law enforcement agencies to dismantle and disrupt drug-trafficking areas.

ONDCP's overall goals are substantial and the stakes are high. They include reducing drug use among our youth, reducing the chronic abuse of a wide range of substances, and lowering drug-related deaths and illnesses.

Despite what often seem to be insurmountable obstacles, ONDCP is making progress on many of these fronts by engaging all of our community stakeholders, from police officers to health professionals.

In 2010, ONDCP took a crucial step in recognizing that addressing drug addiction is not merely a public safety issue, it is a public health issue. We must tackle the demand for drugs as well as their supply. We must recognize that prevention and treatment are crucial tools that complement the law enforcement's efforts.

I have seen up close and personal the ways that drug abuse can be destructive. I've often said that if you want to destroy a people, if you want to destroy a community, and you want to do it slowly but surely, you can do it through drugs.

In my own city of Baltimore I've seen entire communities fractured and broken by drug use. I've seen landmarks like our world famous Lexington Market become synonymous with drug trafficking. I've seen people in so much pain, they don't even know they're in pain. I've seen people who used to be hard-working citizens in our communities staggering through our streets, slumped over from the effects of heroin addiction. Right now, if you went to

Baltimore in certain areas, you will see hundreds of them, people who have lost their way. And this is not the Baltimore where I grew up and it is not the Baltimore I know is possible.

The leaders of the Washington-Baltimore HIDTA hold this conviction too. Over the years, they have demonstrated exactly how prevention and treatment efforts can complement law enforcement efforts. I'm also encouraged that our HIDTA is one of five organizations, as Mr. Connolly said, that will receive $2.5 million to address our Nation's heroin epidemic situation through the Heroin Response Strategy. Using wrap-around, a wrap-around approach that encompasses law enforcement, community involvement, and treatment and prevention strategies, the Washington-Baltimore HIDTA has dismantled 92 drug-trafficking organizations, seized almost 12,000 kilograms of marijuana and nearly 3,000 kilograms of cocaine and 410 kilograms of heroin all since 2013.

It is because of these demonstrated successes that I was pleased to learn that the ONDCP is asking that Congress equip all of its HIDTAs with crucial prevention and treatment tools as well. Today I look forward to learning more about the changes ONDCP is proposing and what it has been doing to address recommendations for improvement provided by the Government Accountability Office.

Finally, this is an issue that affects all of us, it affects all of us, and if it has not affected you yet, I promise you it probably will. Whether you live in west Baltimore or in the mountains of New Hampshire, drug abuse affects every community in America, every one of them.

I look forward to working with all of my colleagues to ensure full and swift reauthorization of ONDCP, a program that is absolutely crucial to the future success, safety, and health of our great Nation.

With that, Mr. Chairman, I thank you, and yield back.

Mr. MEADOWS. I thank the gentleman for his insightful and, I guess, personal words, as it brings it home up close and personal for all of us. I thank the ranking member for that.

I would hold the record open for 5 legislative days for any member who would like to submit a written statement.

Mr. MEADOWS. And the chair has noted the presence of the gentleman from Ohio, earlier has checked in, Mr. Turner, a member of the full committee, and his interest in this particular topic is important. He has stepped out for an Armed Services hearing, but will be back joining us. So without objection, we welcome Mr. Turner to participate fully in today's hearing. Seeing no objection, so ordered.

We will now recognize our panel of witnesses. And I'm pleased to welcome the Honorable Michael Botticelli. Is that correct?

Mr. BOTTICELLI. Botticelli.

Mr. MEADOWS. Botticelli. All right. I'll try to get that better. The Director of the National——

Mr. CONNOLLY. He's more famous for painting paintings.

Mr. MEADOWS. I got you. I got you.

The Director of the National Drug Control Policy at the Office of National Drug Control Policy.

Welcome.

Mr. David Kelley, the congressional liaison at HIDTA, which is the National High Intensity Drug Trafficking Areas Directors Asso-

ciation. And Mr. David Maurer, Director of Justice and Law Enforcement Issues at the GAO.

Welcome to you all.

And pursuant to committee rules, we would ask all witnesses be sworn in before they testify, so if you would please rise and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Thank you. You may be seated.

Let the record reflect that all witnesses answered in the affirmative.

And in order to allow time for discussion, please limit your oral testimony to 5 minutes, if you would, but your entire written statement will be made part of the record.

And, Mr. Botticelli——

Mr. BOTTICELLI. Very well.

Mr. MEADOWS. —we will recognize you for 5 minutes.

WITNESS STATEMENTS

STATEMENT OF MICHAEL BOTTICELLI

Mr. BOTTICELLI. Chairman Meadows, Ranking Member Connolly, Ranking Member Cummings, and members of the committee and subcommittee, thank you for the opportunity to appear before you today to discuss the administration's proposed legislation to reauthorize the Office of National Drug Control Policy. It's truly an honor to be in this position and to be at this hearing today.

ONDCP was established by Congress under the Anti-Drug Abuse Act of 1988 and was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006. As a component of the Executive Office of the President, ONDCP establishes policies, priorities, and objectives of the national drug control program and ensures that adequate resources are provided to implement them. We develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of the executive branch and, to the extent practicable, ensure efforts complement State and local drug policy activities.

ONDCP is responsible for issuing the administration's National Drug Control Strategy, which is our primary blueprint for drug policy. The strategy treats our Nation's substance abuse problems as public health challenges as well as public safety ones, an approach used to address drug control policy since this administration released its inaugural strategy in 2010.

In that strategy, ONDCP set ambitious and aspirational goals for reduction of illegal drug use and its consequences. We knew advancing these goals would be challenging. A careful examination of the most recent data shows that significant progress has been made in many areas, but we know we have far to go in many other areas as well.

For instance, we have moved toward achieving our goals related to reducing chronic cocaine and methamphetamine use and we have met our goals related to reducing lifetime prevalence of tobacco and alcohol use among eighth graders. Looking at our goals

related to the prevalence of illicit drug use by youth and young adults, we find that marijuana use so overwhelms the data that the progress we have achieved in reducing the use of other illicit drugs is not apparent.

In addition to our activities across the interagency to address substance use disorders, ONDCP administers two significant grant programs, the High Intensity Drug Trafficking Area program and the Drug-Free Community Support Program.

The HIDTA program was created as part of ONDCP's original authorization to reduce drug trafficking and production in the United States by facilitating cooperation among Federal, State, local, and tribal law enforcement agencies. The HIDTA program is a locally based program that responds to the drug-trafficking issues facing specific areas of the country in which law enforcement agencies at all levels of government share information, enhance intelligence sharing, and coordinate strategies to reduce the supply of illegal drugs in designated areas. There are currently 28 HIDTA programs in 48 States.

The DFC Program provides grants to local drug-free community coalitions, enabling them to increase collaboration among community partners to prevent and reduce substance use issues. During fiscal year 2015, ONDCP was able to award DFC grants to almost 700 community coalitions.

The reauthorization legislation that the administration has provided to the committee would reauthorization ONDCP for 5 years. The proposed statutory changes would strengthen ONDCP's ability to effectively respond to the range of complex drug problems confronting our Nation today.

The legislation expands the list of authorized demand reduction activities to include screening and brief intervention for substance use disorders, promoting availability and access to healthcare services for the treatment of substance use disorders, and supporting long-term recovery. Language has also been added expressly making the reduction of underage use of alcohol part of ONDCP's demand-reduction responsibilities.

The proposed legislation would also extend authorization for the HIDTA program for 5 years. In addition, the bill will allow HIDTA boards, with the approval of the ONDCP Director, to provide support for programs in the criminal justice system that offer treatment for substance use disorders to drug offenders. Upon the request of a HIDTA executive board, the Director may authorize the expenditure of HIDTA program funds to support initiatives to provide access to treatment as part of a diversion alternative sentencing or community reentry program for drug offenders.

We all know that such programs have proven successful in a number of jurisdictions across the country in breaking the cycle of drug dependence and crime by assisting offenders to overcome their substance use disorder.

New language would also authorize the expenditure of HIDTA program funds for community drug-prevention efforts in excess of the current 5 percent level. Note that these expenditures for prevention and treatment efforts will be driven by the HIDTA executive boards should they see a need and at their discretion. In some instances, the use of a limited amount of funds to support a treat-

ment program for drug offenders or to support a community prevention initiative may be means of reducing drug-related crime.

As we have discussed with the committee, ONDCP intends to rearrange its organizational structure to facilitate greater collaboration among ONDCP's public health, public safety, and international policy staff across the spectrum of drug policy. Our new structure will facilitate the formation of broad-based issue-focused working groups, bringing together staff with policy expertise. This internal reorganization is separate and independent from the reauthorization bill and can largely be accomplished through our existing authorities.

However, as most of the major drug control issues facing our country cannot be placed neatly into demand or supply reduction categories, the proposed authorization would eliminate ONDCP's deputy director positions. Leadership, however, will be overseen by the Director and coordinated through staff.

I am glad to be here to discuss these issues with you in further detail. We are continually grateful for Congress and this committee's support for ONDCP's work to address substance use in this Nation. Thank you.

[Prepared statement of Mr. Botticelli follows:]

Chairman Chaffetz, Ranking Member Cummings, Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee, I am pleased to appear before you today to discuss the Administration's proposed legislation to reauthorize the Office of National Drug Control Policy (ONDCP).

As you know, ONDCP was established by Congress under the Anti-Drug Abuse Act of 1988, with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. November 2015 marked the 27th anniversary of ONDCP, and the Office was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006. As a component of the Executive Office of the President, ONDCP establishes policies, priorities, and objectives for the Nation's drug control programs and ensures that adequate resources are provided to implement them. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and, to the extent practicable, ensure such efforts complement state and local drug policy activities.

In addition, we are charged with producing the *National Drug Control Strategy* (*Strategy*), the Administration's primary blueprint for drug policy, along with a national drug control budget. The *Strategy* is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation's drug problem as a public health challenge, not just a criminal justice issue. It has moved beyond an outdated "war on drugs" approach and is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America. The *Strategy* is rooted in the science of drug addiction as a brain disease – one that can be prevented and treated, and from which people can recover.

As you may know, I am the first person to serve as Director of National Drug Control Policy who is in recovery. I share this with you and in remarks I give to the public because I believe it is important for those of us in recovery from substance use disorders to speak up, to defy stereotypes and strike down the stigma too often associated with people in recovery. The millions of others who are in recovery and I are living proof that substance use disorders are diseases for which treatment works, and recovery is possible. Substance use disorders are medical conditions, and reducing the stigma surrounding these medical conditions is a particularly important component of drug policy reform – one in which every American can play a part.

As Americans work together to address our Nation's shared challenges, improving the health, well-being, and safety of our citizens continues to serve as the basis for strengthening our economy and our country overall. A healthy, productive, and drug-free workforce fosters competitiveness and innovation within our businesses, neighborhoods, towns, and communities. Addressing drug use and its consequences will also ensure our fellow citizens can contribute to our shared successes, and that America's future generations will continue to lead the world in innovation and ingenuity.

Our children, and their children, will only be equipped to compete with their peers around the globe if the United States has a sound economy fueled by an educated, prepared, and healthy workforce. By reducing drug use and its consequences, by teaching children the importance of

healthy and responsible life choices, and by promoting education, innovation, and excellence, we can ensure that the future is ours to win.

The Obama Administration is committed to restoring balance to U.S. drug control efforts by coordinating an unprecedented Government-wide public health and public safety approach to drug policy. In 2010, ONDCP released the Obama Administration's inaugural *Strategy,* which promoted emphasizing community-based drug prevention, integrating evidence-based interventions and treatment into the primary health care system, promoting innovations in the criminal justice system to decrease recidivism, and forging and maintaining strong international partnerships to disrupt drug trafficking organizations.

Since the release of the 2010 *Strategy*, we have seen significant progress in addressing the challenges we face along the entire spectrum of drug policy – including prevention, early intervention, treatment, recovery support, criminal justice reform, law enforcement, and international cooperation. We also still face serious drug-related challenges. Illicit drug use is a public health issue that jeopardizes not only our well-being, but also the progress we have made in strengthening our economy. Last month, we released the 2015 *Strategy*, which provides a review of our progress in implementing the goals we established in the inaugural *Strategy.*

In addition to our work with international partners as part of the comprehensive *Strategy*, we have responsibility for working with Federal agency and international partners in the development of the *National Southwest Border Counternarcotics Strategy* and the *National Northern Border Counternarcotics Strategy*, and earlier this year, ONDCP released a *National Caribbean Border Counternarcotics Strategy*. These strategies put the goals, strategies and action items of the *National Drug Control Strategy* into more regionally-based focus to help disrupt the trafficking of illegal drugs into this country while enhancing our efforts to provide border communities with enhanced prevention and drug treatment assistance that will help curb drug use in the long term.

ONDCP Grant Programs

In addition to our activities across the interagency, ONDCP administers two significant grant programs – the High Intensity Drug Trafficking Areas (HIDTA) Program and the Drug-Free Communities (DFC) Support Program.

High Intensity Drug Trafficking Areas Program

The HIDTA Program was created as part of ONDCP's original authorization to reduce drug trafficking and production in the United States by facilitating cooperation among Federal, state, local, and tribal law enforcement agencies. The HIDTA Program is a locally-based program that responds to the drug trafficking issues facing specific areas of the country. Law enforcement agencies at all levels of government share information and implement coordinated enforcement activities; enhance intelligence sharing among Federal, state, local, and tribal law enforcement agencies; provide reliable intelligence to law enforcement agencies to develop effective enforcement strategies and operations; and support coordinated law enforcement strategies to maximize available resources and reduce the supply of illegal drugs in designated areas. There are currently 28 HIDTAs located in 48 states, as well as in Puerto Rico, the U.S. Virgin Islands, and the District of Columbia.

In addition to the individual initiatives supported by the 28 HIDTAs, there are three national initiatives supported by the HIDTA Program: the Domestic Highway Enforcement Program, the National Marijuana Initiative (NMI), and the National Methamphetamine and Pharmaceuticals Initiative (NMPI). NMI and NMPI are training and best practices initiatives.

The HIDTA program helps improve the effectiveness and efficiency of drug-control efforts by facilitating cooperation between drug-control organizations through resource and information sharing, and co-locating and implementing joint initiatives. HIDTA funds help Federal, state, local, and tribal law enforcement organizations invest in infrastructure and joint initiatives to confront drug-trafficking organizations.

Currently, 27 regional HIDTA programs support prevention initiatives, connecting law enforcement with local prevention efforts to support best-practice activities designed to reduce drug use by replicating the HIDTA multi-agency model. HIDTA members work with community-based coalitions and adhere to evidence-based prevention practices, such as community mobilization and organizational change.

The HIDTA program's primary mission is to dismantle and disrupt drug trafficking organizations. However, expanding prevention efforts offers HIDTAs the ability to address the drug threat in a community in a more comprehensive fashion. As recently as 2010, only four HIDTAs used funding for prevention initiatives. Currently, 27 HIDTAs, including all 5 Southwest Border HIDTA Regions, sponsor prevention activities. Eight HIDTAs (Houston, Michigan, Northwest, Puerto Rico, Southwest Border-Arizona and San Diego/Imperial Valley Regions, Texoma, Washington/Baltimore, and Wisconsin) specifically target marijuana, among other substances, in their prevention efforts.

This past summer, ONDCP committed $2.5 million in HIDTA funds to develop a strategy to respond to the Nation's heroin epidemic. This unprecedented project by ONDCP combines prevention, education, intelligence, and enforcement resources to address the heroin threat across 15 states and the District of Columbia. The effort will be carried out through a unique partnership of five regional HIDTA programs – Appalachia, New England, New York/New Jersey, Philadelphia/Camden, and Washington/Baltimore.

Drug-Free Communities Support Program

The DFC Support Program, created by the Drug Free Communities Act of 1997, serves as the Nation's leading effort to mobilize communities to prevent youth drug use. Directed by ONDCP in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services, the DFC Program provides grants to local drug-free community coalitions, enabling them to increase collaboration among community partners and to prevent and reduce youth substance use. ONDCP provides oversight of the DFC Support Program to include final award determination, program regulation, policy, and its national evaluation.

During Fiscal Year (FY) 2015, following a competitive grant process a total of 697 DFC grants were awarded to 188 new DFC grantees, 486 DFC continuation grantees, and 23 DFC Mentoring

grantees. These awards followed a competitive grant process. The most recent evaluation of the DFC program found that, between DFC coalitions' first report and most recent report, rates of substance abuse are continuing to decline in DFC communities. The DFC 2014 National Evaluation Report showed a significant decrease in past 30 day use of prescription drugs among youth in DFC communities. The report also noted increases in the perception of risk, perception of peer disapproval, and perception of parent disapproval in relation to non-medical prescription drug use. The report also found a significant decrease in past 30 day use between the first and most recent data reports for alcohol, tobacco, and marijuana use among middle school and high school youth in DFC communities.[1]

Overview of Drug Trends

SAMHSA's 2014 National Survey on Drug Use and Health shows signs of progress in reducing some forms of substance use, including lower levels of nonmedical prescription drug use and teen alcohol and tobacco use. The number of past-month cocaine users is significantly lower than it was in the early 2000s.[2] However, challenges remain.

Opioid Drug Use

The nonmedical use of opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone, and hydrocodone – is having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention, approximately 120 Americans on average died from a drug overdose every day in 2013. Of the nearly 44,000 drug overdose deaths in 2013, opioid pain relievers were involved in over 16,200, while heroin was involved in over 8,200. Overall, drug overdose deaths now outnumber deaths from gunshot wounds (over 33,600) or motor vehicle crashes (over 32,700)[3] in the United States.[4] Heroin use remains relatively low in the United States when compared to other drugs; however, the increase in the number of people using the drug in recent years – from 373,000 past-year users in 2007 to 914,000 in 2014[5] – and the high rate of overdose deaths are troubling.

There has been considerable discussion around potential connections between the non-medical use of prescription opioids and heroin use. There is evidence to suggest that some users eventually begin to substitute heroin for prescription opioids, which are often more expensive than heroin. While research into the potential nexus between these two types of opioids remains sparse, a SAMHSA report found that four out of five (79.5%) recent heroin initiates had previously used prescription pain relievers non-medically. However, only a very small proportion (3.6%) of those who had started using prescription opioids non-medically initiated

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[1] ICF International. Drug Free Communities Support Program 2014 National Evaluation Report. Available at: https://www.whitehouse.gov/sites/default/files/DFC2014Interim%20ReportJuly2015Final.pdf

[2] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Table 7.3A – Types of Illicit Drug Use in the Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-3a

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

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

[5] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Table 7.2A – Types of Illicit Drug Use in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-2a

heroin use in the following five-year period.[6] This suggests that while most new heroin users have previously used prescription opioids non-medically, a very small portion of all non-medical prescription opioid users transitions to heroin.

In April 2011 the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)* entitled, "Epidemic: Responding to America's Prescription Drug Abuse Crisis." This *Plan* builds upon the *Strategy* and brings together Federal, state, local, and tribal leaders to reduce diversion and abuse of prescription drugs. It strikes a balance between our need to prevent the diversion and nonmedical use of pharmaceuticals with the need to ensure legitimate access to them. The *Plan* focuses on improving education for patients and healthcare providers, supporting the expansion of state-based prescription drug monitoring programs, developing more convenient and environmentally responsible disposal methods to remove unused medications from the home, and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts. The Administration has made considerable progress in implementing all four areas of the *Plan*.

This progress was highlighted on October 21 during President Obama's trip to West Virginia, where I accompanied the President to hear directly from individuals, families, and law enforcement officials affected by the opioid epidemic. As part of this visit, the President announced additional Federal, state, local and private sector efforts aimed at addressing the consequences of nonmedical prescription opioid and heroin use. In addition, the President issued a memorandum to Federal departments and agencies directing important steps to address this epidemic.

In May, the Administration inaugurated the congressionally-mandated interagency Heroin Task Force, which is co-chaired by ONDCP and DOJ. The Task Force includes Federal agency experts from law enforcement, medicine, public health and education. In a few weeks, the Task Force will produce a report focused on evidence-based public health and public safety recommendations to reduce the health and safety consequences of opioid use and the supply and demand of opioids. With the cooperation of the National Security Council (NSC), ONDCP has recently established the National Heroin Coordination Group (NHCG), a diverse, multi-disciplinary team of subject matter experts that will lead interagency efforts to reduce the availability of heroin in the United States. The NHCG will work with the NSC to guide and synchronize interagency activities against the heroin/fentanyl supply.

Since much of the heroin that is coming into the United States across our Southwest border is produced in Mexico, during recent high-level discussions in Mexico City I discussed in detail the opioid/heroin challenge with Mexican counterparts. We expect expanded efforts to reduce the production and trafficking of heroin by Mexico-based drug cartels to be initiated in the near term.

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

New Psychoactive Substance Use

New Psychoactive Substances (NPS) such as synthetic cannabinoids, sometimes referred to as "K2," and synthetic cathinones, commonly referred to as "bath salts," present an array of health and safety risks. The contents and effects of these substances are unpredictable due to a constantly changing variety of chemical compounds used in manufacturing processes that are devoid of quality controls and regulatory oversight.

The use of NPS is burdening our health care system. According to a 2013 report by SAMHSA's Drug Abuse Warning Network, 28,531 emergency department visits involving a synthetic cannabinoid product occurred in 2011, a figure 2.5 times higher than the 11,406 emergency department visits just a year earlier in 2010.[7] Reporting also found that bath salts were involved in 22,904 emergency department visits in 2011, highlighting the considerable toll these drugs are taking in health care settings nationwide.[8] According to information from the American Association of Poison Control Centers, counts for synthetic cannabinoid cases reported to poison control centers peaked in 2011 with 6,968 but decreased through 2014. However, as of October 31, 2015, poison centers have received 6,949 reported exposures to synthetic cannabinoids, a trajectory which will likely make 2015 the year with the highest number of cases reported.[9]

ONDCP is working with Federal, state, local, and community partners throughout the country, as well as regionally and internationally, to address the dynamic problem of NPS. Through directives in our national strategies and action plans related to reducing drug use and its consequences, we are working closely with the international community and China, where the majority of these chemicals are produced, to address manufacturing; Congress to improve regulatory tools to schedule NPS; law enforcement to support their investigations both domestically and abroad; the research community to better understand the effects of these substances; and prevention stakeholders, parents, and community organizations to inform about the dangers of NPS.

DFC coalitions across the country have identified NPS as a growing problem in their communities and have taken action. For example, the Franklin Mayor's Drug and Alcohol Abuse Task Force in New Hampshire worked to adopt the first synthetic cannabinoid ordinance in that state. The ordinance brought the issue of NPS to the forefront in the community, as many residents had never heard of "K2" or "Spice," and many did not know that they were being sold in Franklin convenience stores. Other cities in New Hampshire have since reached out to Franklin as they consider adopting similar laws. Another DFC grantee, the Clinton Substance Abuse Council in Iowa, worked with the Clinton Police Department to facilitate an NPS drop off day for retailers. And in California, the Santee Solutions Coalition in Santee helped local law enforcement identify businesses selling NPS. These are just a few examples of the many DFC grantees around the country seeking to educate their communities about these dangerous substances.

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[7] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. May 2013. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm

[8] Substance Abuse and Mental Health Services Administration, *The DAWN Report Data Spotlight: "Bath Salts" Were Involved in Over 20,000 Drug-Related Emergency Department Visits in 2011*. September 2013. Available at: http://www.samhsa.gov/data/sites/default/files/spot117-bath-salts-2013/spot117-bath-salts-2013.pdf.

[9] American Association of Poison Control Centers. Synthetic Cannabinoid Data. https://aapcc.s3.amazonaws.com/files/library/Syn_Marijuana_Web_Data_through_10.31.15.pdf

U.S. drug control agencies are also working to address the supply of NPS. Many of the chemical compounds that are used to manufacture NPS originate in Asia. Dialogue with China, in particular, appears to have resulted in greater control efforts in that country. In addition, interdiction agencies are working to track and disrupt the flow of NPS from Asia and continue to work towards tightening monitoring of these chemical shipments.

Methamphetamine

Southwest border seizure data,[10] law enforcement reporting,[11] localized drug consequence information such as treatment admissions,[12] and overdose data[13] all indicate that methamphetamine trafficking and use continue to pose an increasing threat to the United States. Mexican transnational criminal organizations (TCOs) have adapted to legal restrictions placed on precursor chemicals, in the United States and Mexico, and are able to continue producing large amounts of high-purity, high-potency methamphetamine. The majority of methamphetamine available in the United States is Mexican cartel-produced.[14] This methamphetamine relies on precursor chemicals from China and India. To address this issue, ONDCP and our interagency partners at the U.S. Department of State, the Drug Enforcement Administration, and the U.S. Pacific Command are engaging with international partners in Asia, as well as multilateral organizations and key bilateral partners, to improve international controls of precursor chemicals. We are also working to improve the capacity of Mexico and Central American nations to detect, seize and safely dispose of diverted precursors. In addition, SAMHSA and NIDA, for example, are helping to educate and inform the public about the risks associated with methamphetamine, as well as supporting basic molecular and neuroscience research, prevention strategies, medications development, and clinical research testing new treatment strategies for this drug.

Cocaine

While cocaine smuggling, availability, and consumption in the United States are all down when compared to historically high levels in the mid-2000s, we need to be attentive to the potential resurgence of cocaine, as indicated by recent potential production estimates[15] and transit zone seizures.[16] Cocaine production estimates have been increasing, and the Consolidated Counterdrug Data Base shows a commensurate increase in the flow of cocaine through the Western Hemisphere Transit Zone. Mexican TCOs obtain multi-ton shipments of cocaine from source countries in South America, primarily from Colombia. In 2014, an estimated 86 percent of this cocaine was smuggled through the Mexico/Central America corridor.[17] Mexican TCOs smuggle the majority of U.S.-bound cocaine across the Southwest border. After large loads reach shipment points in Mexico or Central America, they are broken down into small, more difficult-to-detect loads that are smuggled across the Southwest border into the United States. The U.S.

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[10] National Seizure System (NSS), El Paso Intelligence Center

[11] Drug Enforcement Administration, 2015. National Drug Threat Assessment Summary, August 2015, p. 49.

[12] Preliminary 2013-14 Treatment Episode Data Set (TEDS), SAMHSA, http://www.samhsa.gov/data/sites/default/files/2014_TEDS_Substance_Abuse_Treatment_Admissions_Tables_as_of_2015_Q2/2014_TEDS_Substance_Abuse_Treatment_Admissions_Tables_as_of_2015_Q2.html

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

[14] Drug Enforcement Administration, 2015. National Drug Threat Assessment Summary, August 2015, p. 53.

[15] U.S. Government Colombia illicit crop estimates, April 2015.

[16] Consolidated Counterdrug Data Base (CCDB), October, 2015.

[17] Interagency Assessment of Cocaine Movement, DIA, 2014

Government is strongly supportive of the Colombian peace process, but we also want to make sure that as Colombia moves forward on what would be an historic accomplishment, that efforts to constrain any increases in cocaine production are maintained.

Marijuana Use

Marijuana is the most commonly used illicit drug in the United States. In 2014 alone, nearly 35 million people ages 12 and older reported using the drug within the past year.[18] A substantial portion of these Americans were using marijuana nearly every day in the past 12 months. In 2014, 18.5 percent of Americans 12 or older who had used marijuana in the past year did so on 300 or more days within the past 12 months,[19] or over 6.5 million people using marijuana on a daily or almost daily basis during that period.[20] Moreover, approximately 4.2 million people met the diagnostic criteria for abuse or dependence on this drug, more than for any other drug.[21] When we look at our progress in meeting the *Strategy*'s 5-year goals related to reducing the 30-day prevalence of use of illicit drugs by youth and young adults, we find that marijuana use overwhelms the data to such an extent that the progress achieved toward reducing use of other illicit drugs is no longer apparent when marijuana use is included.

ONDCP is taking a number of steps to prevent marijuana use, particularly with young people and parents. DFC coalitions across the country have identified marijuana as a significant problem in their communities. In fact, nearly 90 percent of FY 2012 DFC coalitions list marijuana as one of their top 5 targeted substances and are taking action to prevent young people from using the drug.[22] These coalitions employ a host of prevention strategies, including disseminating multi-lingual educational materials, hosting drug-free social events for youth, working with schools and educators to promote drug free campuses, and working with local media to highlight prevention activities.

ONDCP also works closely with other drug control agencies to advance our understanding of the health implications of marijuana; enhance surveillance about the extent and health impacts of marijuana use; provide information and technical assistance to state and Federal officials, and the broader public, based on scientific understandings, with a focus on preventing youth use; ensure required health insurance coverage for screening and medical treatment services include substance use; and provide substance use prevention, treatment and recovery support services through publicly-supported programs.

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[18] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 6.1A – Number of Days Used Marijuana in the Past Year among Past Year Users and the Number of Days Used Marijuana in the Past Month among Past Month Users, by Age Group: Numbers in Thousands, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-1a

[19] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 6.1B – Number of Days Used Marijuana in the Past Year among Past Year Users and the Number of Days Used Marijuana in the Past Month among Past Month Users, by Age Group: Percentages, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-1b

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

[21] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 5.2A – Substance Dependence or Abuse for Specific Substances in the Past Year, by Age Group: Numbers in Thousands, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab5-2a

[22] Unpublished Drug Free Communities Support Program Evaluation Tracking.

ONDCP Reauthorization Bill

The reauthorization legislation that the Administration has provided to the Chairman and Ranking Member would reauthorize ONDCP through FY 2020. The proposed statutory changes would strengthen ONDCP's ability to effectively respond to the range of complex drug problems confronting our Nation today.

The legislation contains new language reflecting the expanded public health approach to drug policy that ONDCP is undertaking in accordance with the *National Drug Control Strategy*. It explains that the term "demand reduction" encompasses, "prevention, treatment and recovery efforts," and expands the list of authorized demand reduction activities to include: 1) screening and brief interventions for substance use disorders; 2) promoting availability of and access to health care services for the treatment of substance use disorders; and 3) supporting long-term recovery from substance use disorders. These activities all come within ONDCP's existing authorities, and the Office has significantly increased its focus on the availability of medical treatment and recovery support for individuals with substance use disorders. Currently, less than one fifth of those who need specialty treatment for their illicit drug use problem receive it. Including these specific elements of care in the statute on the list of enumerated demand reduction activities will further highlight their importance.

Language has also been added expressly making the reduction of underage use of alcohol part of ONDCP's demand reduction responsibilities. The percentage of adolescents aged 12 to 17 who were current alcohol users was 11.5 percent in 2014. This percentage corresponds to 2.9 million adolescents in 2014, about 1 in 9 adolescents, who drank alcohol in the past month.[23] There is a strong body of evidence linking underage alcohol use and unlawful drug use among teenagers and young adults, and an effective effort to reduce substance use within this population must address both of these related concerns. This has been part of ONDCP's prevention work in the past, and given the important role of youth prevention in averting substance use disorders, it warrants increased attention and a more focused response.

The proposed legislation would also extend authorization for the HIDTA Program through FY 2020 to allow the HIDTA Program to continue providing vital support for joint initiatives by Federal, state, local, and tribal law enforcement targeting illegal drug operations. In addition, the bill would allow local HIDTA boards, with the approval of the Director of ONDCP, to provide support for programs in the criminal justice system that offer treatment for substance use disorders to drug offenders, and to provide support for community prevention efforts.

The pertinent language in the proposed reauthorization states that upon the request of an Executive Board of a High Intensity Drug Trafficking Area, the Director may authorize the expenditure of HIDTA Program funds to support initiatives that provide access to treatment for substance use disorders as part of a diversion or alternative sentencing or community reentry program for drug offenders. Such programs have proven successful in a number of jurisdictions across the country in breaking the cycle of drug dependence and crime by assisting offenders to overcome their substance use disorders. ONDCP's previous authorization prohibited the use of

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[23] Substance Abuse and Mental Health Services Administration. *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* Results from the *2014*. Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#fig25

funds for "the establishment or expansion of drug treatment programs." The Washington-Baltimore HIDTA has traditionally provided ongoing funding to the District of Columbia drug court, an initiative started before the prohibition was placed in the previous reauthorization. This initiative is an example of the type of program that the proposed reauthorization language would allow to be further supported by the HIDTAs. New language is also added stating that upon the request of a HIDTA Executive Board, the Director of ONDCP may authorize the expenditure of an amount greater than five percent of HIDTA Program funds for drug prevention efforts. Current law authorizes the Director to expend up to five percent of HIDTA program funds for drug prevention. With this modification, HIDTAs could increase the level of support for prevention efforts in their communities, should they see a need and at their discretion.

HIDTA board members come primarily from the law enforcement community and from the geographic areas they serve. They best know the needs of their communities. In some instances, the use of a limited amount of funds to support a treatment program for drug offenders or to support a community prevention initiative may, in the eyes of a local HIDTA board, assist in fulfilling the primary duties of the HIDTA. That is a decision each HIDTA board should have the authority to make. The proposed amendment would grant HIDTA boards that authority.

As we have discussed with the Committee, ONDCP intends to rearrange its organizational structure to facilitate greater collaboration among ONDCP's public health, public safety, and international policy staff across the spectrum of drug policy. Most of the major drug control issues our country is facing today do not fall neatly into the traditional "demand" or "supply" categories. A comprehensive response requires that we address the treatment, prevention, law enforcement, and source country aspects of each drug threat holistically. Our proposed new structure will facilitate the formation of broad-based, issue-focused working groups bringing together staff with expertise in each of these policy areas.

This internal reorganization plan is separate and independent from the reauthorization bill that the Committee is considering. Most of the reorganization can be implemented under ONDCP's existing statutory authority and does not require any statutory change. However, current law provides for the appointment of the Deputy Directors for Demand Reduction, Supply Reduction, and State, Local, and Tribal Affairs. As most of the major drug control issues facing our country do not fall neatly into these traditional categories, we are proposing to eliminate the deputy director positions effective January 20, 2017. The leadership responsibilities of the deputy directors will be overseen by the Director, to be coordinated by him through supervisory staff members.

These are the most significant changes contained in the proposed ONDCP reauthorization bill. We have provided the Committee with a document describing all of the proposed changes in detail.

Conclusion

As the above discussion indicates, the Office of National Drug Control Policy is involved in a large variety of activities to coordinate Federal, state, local, tribal, and international partners to address substance use disorders in this Nation. ONDCP supports a comprehensive public health and safety approach in an effort to reduce drug use and its consequences, as well as the

availability of illicit drugs. The Administration's proposed legislation to reauthorize ONDCP reflects this 21st century approach to drug policy that is set out in the Administration's *National Drug Control Strategy*. We appreciate the Committee's ongoing interest in working with ONDCP on drug policy matters.

Mr. MEADOWS. Thank you very much for your testimony.
Mr. Kelley, you're recognized for 5 minutes.

STATEMENT OF DAVID KELLEY

Mr. KELLEY. Thank you. Chairman Meadows, Ranking Member Connolly, Ranking Member Cummings, and distinguished members of the subcommittee, I'm honored to appear before you today to offer testimony highlighting the High Intensity Drug Trafficking Area program and to speak to the reauthorization of the Office of National Drug Control Policy, specifically to the recommendations of the HIDTA directors with regard to proposed reauthorization language.

ONDCP establishes priorities and objectives for the Nation's drug policy. The Director is charged with producing the National Drug Control Strategy that directs the Nation's efforts. The current strategy promotes a focused and balanced approach.

The HIDTA program is an essential component of the National Drug Control Strategy. The 28 regional HIDTAs are in 48 States, Puerto Rico, the U.S. Virgin Islands, and the District of Columbia. HIDTAs enhance and coordinate anti-drug abuse efforts from a local, regional, and national perspective, leveraging resources at all levels in a true partnership.

At the national level, ONDCP provides policy direction and guidance to the HIDTA program. At the local level, each HIDTA is governed by an executive board comprised of an equal number of Federal, State, local, and tribal agencies. This provides a balanced and equal voice in identifying regional threats, developing strategies, and assessing performance.

The flexibility of this leadership model creates the ability for the executive board to quickly, effectively, efficiently adapt to emerging threats that may be unique to their own HIDTAs. Investigative support centers in each HIDTA create a communication infrastructure that facilitates information sharing among law enforcement agencies to effectively reduce the production, transportation, distribution, and use of drugs.

The strengths of the HIDTA program are truly multidimensional. One of the cornerstones of the program is its demonstrated ability to bring people and agencies together to work toward a common goal.

The neutrality of the HIDTA program is viewed as another key to its success. HIDTA is a program, not an agency. HIDTAs do not espouse the views of any one agency, nor are we beholden to the mandates of any one agency. HIDTA serves only to facilitate and coordinate.

While the enforcement mission remains paramount, HIDTAs are also involved in drug-prevention activities. The fact that we cannot arrest our way out of this drug problem is well recognized in the law enforcement community. The emerging partnership between public health and public safety has never been more important, and HIDTA provides the perfect platform to promote that partnership.

The Washington-Baltimore HIDTA seeks to break the cycle of drug abuse and crime through well-organized criminal justice-

based treatment programs. The focus is to reduce crime in targeted communities and change the drug habits of repeat offenders.

The New England HIDTA has partnered with the Boston University School of Medicine SCOPE of Pain program. Here, the opioid heroin epidemic is addressed at the front end through extensive prescriber education. Through an innovative use of discretionary funding, five HIDTAs have jointly developed a heroin response strategy to address the severe heroin threat in their communities. The strategy provides a unique, unprecedented platform designed to enhance public health, public safety collaboration across 15 States.

ONDCP and the HIDTA program currently enjoy a collaborative and cooperative working relationship that has never been stronger. The National HIDTA Directors Association strongly encourages Congress to reauthorize ONDCP during this session.

The National HIDTA Directors Association supports the existing language of the ONDCP Reauthorization Act of 2015, with three exceptions. First, the existing authorization specifies that the Director shall ensure that no Federal funds appropriated for the program are expended for the establishment or expansion of treatment programs. The proposed revision of this prohibition would allow the Director, upon request of a HIDTA executive board, to authorize the expenditure of program funds to support drug treatment programs. We support this change, but believe that funding should not exceed a cap of 10 percent of the affected HIDTA's baseline budget.

Second, in the past, no more than 5 percent of HIDTA funds could be expended for the establishment of drug prevention programs. The new wording allows the Director, upon request of the HIDTA executive board, to authorize the expenditure of an amount greater than 5 percent of program funds. We support this change, but again believe that funding should not exceed a cap, a maximum cap of 10 percent of the affected HIDTA's baseline budget.

Third, and finally, the language authorizes an appropriation to ONDCP of $193.4 million for the HIDTA program. This amounts to a 22 percent reduction in program funding. This reduction would severely handicap the HIDTA program. The National HIDTA Directors Association respectfully recommends funding in the amount of $245 million, which was the amount awarded in fiscal year 2015.

I thank you for allowing me this opportunity to testify before you this morning and I look forward to answering your questions.

[Prepared statement of Mr. Kelley follows:]

STATEMENT OF

David W. Kelley
Congressional Affairs Liaison, National HIDTA Directors Association
Deputy Director, New England High Intensity Drug Trafficking Area

before the

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

EXAMINATION OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY AND ITS EFFORTS TO COORDINATE DRUG POLICY ACROSS THE FEDERAL GOVERNMENT

December 2, 2015
Washington, DC

Chairman Meadows, Ranking Member Connolly, and distinguished members of the Subcommittee, I am honored to appear before you today on behalf of the members of the National HIDTA Directors Association (NHDA). I am thankful for the opportunity to offer testimony highlighting the mission, goals, objectives, and vast scope of the High Intensity Drug Trafficking Area Program (HIDTA). I also wish to speak to the very important issue of the reauthorization of the Office of National Drug Control Policy (ONDCP), particularly as it relates to the role of the HIDTA program, and more specifically to the recommendations of the HIDTA Directors with regard to proposed language allowing for the establishment or expansion of drug treatment and prevention programs under the ONDCP Reauthorization Act of 2015.

Illicit drug use and its consequences continue to constitute dynamic and challenging threats to the United States. Communities across this nation, whether urban, suburban, or rural, are in the midst of a public health and public safety crisis. We must understand that the scourge of drug abuse has no boundaries. It does not recognize geography, social or economic status, race, gender, or age. It is an equal opportunity threat to our well-being. The abuse of opioids, a group of drugs that includes heroin and prescription painkillers, expose the addicted to the risk of death each and every day, the scourge of methamphetamine devastates communities in its wake, and

the emergence of synthetic cannabinoids and cathinones gives rise to increasing levels of violence. These are but a few examples of the far reaching drug challenges we face. Drug trafficking organizations that prey upon our communities and the criminal activity associated with them can be found in every part of the United States. This underscores the need for a comprehensive approach- a multi-disciplinary, holistic strategy- to address the prevailing public health and public safety issues raised by drug abuse and misuse in our society.

The Office of National Drug Control Policy has the important responsibility to establish priorities and objectives for the nation's drug policy, which includes treatment, prevention and law enforcement. The goals include reducing illicit drug use, trafficking, drug-related crime and violence, and drug-related health consequences. To achieve these goals, the Director of ONDCP is charged with producing the National Drug Control Strategy (NDCS) that directs the nation's efforts and establishes a budget and guidelines for cooperation among federal, state, local and tribal entities. The current NDCS promotes a focused approach, balancing the public health and public safety aspects of drug use and substance abuse disorders.

The High Intensity Drug Trafficking Area Program is an essential component of the National Drug Control Strategy. It is clear that federal, state, local, and tribal law enforcement plays an integral role in the balanced strategy to reducing drug use and its consequences. The mission of the HIDTA program is to disrupt the market for illegal drugs by dismantling or disrupting drug trafficking organizations in order to eliminate or reduce drug trafficking and its harmful consequences in critical regions of the United States. There are 28 regional HIDTAs throughout the United States. The HIDTAs include 17 percent of all counties in the nation and 60 percent of the population. HIDTA designated counties are in 48 states, as well as Puerto Rico, the US Virgin Islands, and the District of Columbia. The individual HIDTAs enhance and coordinate federal, state, local and tribal anti-drug abuse efforts from a local, regional, and national perspective, leveraging resources at all levels in a true partnership.

At the national level, ONDCP provides policy direction and guidance, and grant administration to the HIDTA program. At the local level, each HIDTA is governed by an Executive Board comprised of an equal number of federal agencies and participating state, local, and tribal

agencies. The Executive Board provides direction and oversight in establishing and achieving the goals of the individual HIDTA. The HIDTA program gives the federal, state, local and tribal criminal justice leaders a balanced and equal voice in identifying the regional threat, developing a strategy, investing in that strategy, and assessing performance. The flexibility of this leadership model creates the ability for the Executive Board to quickly, effectively, and efficiently adapt to emerging threats that may be unique to their HIDTA by redirecting resources as necessary to provide for the greatest level of impact. To highlight program success in disrupting the market for illegal drugs, in 2014 the HIDTA program disrupted or dismantled 835 international, 960 multi-state, and 1,067 local drug trafficking organizations, removing over $15 billion dollars in wholesale value of illicit drugs, and over $1 billion in illegally gained assets from drug traffickers.

Intelligence and information sharing is a critical component of the overall strategy to reduce the market for illegal drugs. The HIDTA program establishes Investigative Support Centers in designated areas, specifically to create a communication infrastructure that can facilitate information sharing among federal, state, local and tribal law enforcement agencies. The HIDTA Directors believe that information gleaned from the collection, evaluation, analysis and synthesis of intelligence must be shared in order to effectively reduce the production, transportation, distribution, and use of drugs. As evidence of this fact, HIDTA intelligence centers in 2014 supported over 26,000 investigations, referred over 58,000 investigative leads, and entered over 274,000 tactical operations in deconfliction systems designed to ensure officer safety and investigative integrity.

Training is an essential ingredient to improve the efficiency and effectiveness of HIDTA initiatives. The HIDTA training curriculum makes a significant contribution to advancing the knowledge, skills, and abilities of drug law enforcement, treatment, and prevention professionals, while also offering unique networking opportunities across agencies and disciplines.

The strengths of the HIDTA program are truly multi-dimensional. One of the cornerstones of the program is its demonstrated ability to bring people and agencies together to work toward a common goal. The neutrality of the HIDTA program is viewed as another key to its success.

HIDTA is not an agency, does not espouse the views of any one agency, and is not beholden to the mandates of any one agency. HIDTA is truly an agency neutral program that serves only to facilitate and coordinate. HIDTA's strength can also found in its innovation, expanded scope of mission, and diversity. The program embraces a balanced and holistic approach to address prevailing drug issues that require a multi-disciplinary and multi-faceted plan of action. While the primary mission focus of enforcement remains of paramount importance, HIDTAs throughout the nation are also involved in drug prevention activities that stress training, partnership, sponsorship and community outreach. The fact that we cannot arrest our way out of this drug problem is well recognized by the law enforcement community. The emerging partnership between public health and public safety has never been more important and HIDTA provides the perfect platform to promote that partnership.

The HIDTA program has been at the forefront of establishing, coordinating, and supporting innovative approaches in partnership with relevant disciplines to stem the tide of drug abuse. The Washington-Baltimore HIDTA, through its HIDTA Treatment/Criminal Justice component, seeks to break the cycle of drug abuse and crime through well-organized, criminal justice based treatment programs that incorporate graduated sanctions, drug testing and intensive supervision of offenders who are under correctional control. The focus is to reduce crime in targeted communities and change the drug habits of repeat offenders. In New England, the HIDTA has partnered with the Boston University School of Medicine's nationally renowned Safe and Competent Opioid Prescribing Education program. Well aware of the fact that opioid/heroin abuse is at epidemic levels, and with the full understanding of the need to employ a multi-pronged approach, the New England HIDTA's posture is to address this emergent drug threat on the front end, through the support of prescriber education as well as through traditional and non-traditional enforcement efforts. Through an innovative use of discretionary funding, five HIDTAs - New England, New York/New Jersey, Philadelphia/Camden, Washington/Baltimore, and Appalachia have jointly developed a Heroin Response Strategy (HRS) to address the severe heroin threat in their communities. The HRS provides a unique, unprecedented platform, designed to enhance public health-public safety collaboration across 15 states, as well as to advance drug use prevention efforts throughout the region, with the overarching goal of reducing drug overdose deaths.

The synergistic effect of enforcement, treatment, prevention, and education working together across disciplines towards a common goal of a sustainable quality of life in the community that allows our citizens to remain healthy and achieve their full potential, is a noteworthy pursuit.

ONDCP and the HIDTA program have developed a partnership that has been instrumental in the continuing success of HIDTA. In fact, the collaborative and cooperative working relationship that currently exists has never been stronger. It is a partnership that will pave the way for greater achievement in the face of future challenges. The National HIDTA Directors Association strongly encourages Congress to reauthorize the Office of National Drug Control Policy during this session. Moreover, the reauthorization of ONDCP at this critical juncture would surely demonstrate the unwavering commitment of our national leaders to safeguard the health and safety of our nation. With that said, the National HIDTA Directors Association supports the existing language in the ONDCP Reauthorization Act of 2015 with three exceptions:

(1) The existing authorization specifies that "the Director shall ensure that no Federal funds appropriated for the [HIDTA] Program are expended for the establishment or expansion of drug treatment programs." The proposed revision of this prohibition would allow the ONDCP Director, upon the request of a HIDTA Executive Board, to authorize the expenditure of program funds to support drug treatment programs. The HIDTA Directors recognize that there may be times when it would be appropriate to spend some funds to further collaborate with demand reduction programs such as the drug courts and other alternative sentencing programs. We support this change but believe funding should not exceed a cap of 10 percent of the affected HIDTA's baseline budget.

(2) In the past, no more than 5 percent of HIDTA funds could be "expended for the establishment of drug prevention programs." The new wording allows the ONDCP Director, upon request of a HIDTA Executive Board, "to authorize the expenditure of an amount greater than 5 percent of Program funds." We support this change but

believe that funding should not exceed a cap of 10 percent of the affected HIDTA's baseline budget.

(3) The language authorizes the appropriation to ONDCP of $193,400,000 for FY 2016 for the HIDTA program. In FY 2014 and years prior to that, Congress authorized $238.5 million for the HIDTA program. In FY 2015, Congress authorized $245 million for the HIDTA program. The amount in the proposed language of the bill would amount to a 22 percent reduction in HIDTA program funding. This reduction would severely handicap the HIDTA program in accomplishing its goals and objectives. The National HIDTA Directors Association would respectfully recommend that the language reflect funding in the amount of $245 million as the minimum funding appropriation, which was the amount awarded in FY 2015.

Thank you for allowing me this opportunity to testify before you today. I look forward to answering your questions.

Mr. MEADOWS. Thank you, Mr. Kelley, for your testimony.
Mr. Maurer.

STATEMENT OF DAVID MAURER

Mr. MAURER. Good morning, Chairman Meadows, Ranking Member Cummings, Ranking Member Connolly, and other members and staff. I'm pleased to be here today to discuss GAO's findings on Federal efforts to curtail illicit drug use and enhance coordination among Federal, State, and local agencies.

Combating drug use and dealing with its effects is an expensive proposition. The administration requested more than $27 billion to undertake these activities in 2016. Ensuring this money is well spent, that we're making progress, and that the various agencies are well coordinated is vitally important.

Over the years, GAO has helped Congress and the American public assess how well Federal programs are working. In many instances, it's, frankly, hard to tell, because agencies often don't have good enough performance measures. ONDCP, to its credit, has focused a great deal of time, attention, and resources on developing and using performance measures.

Five years ago, the National Drug Control Strategy established a series of goals with specific outcomes ONDCP hoped to achieve by 2015. In 2013, we reported that a related set of measures were generally consistent with effective performance management and useful for decisionmaking. That's important to remember, especially when the conversation turns to what those measures tell us.

Overall, there has been a lack of progress. According to a report ONDCP issued 2 weeks ago, none of the seven goals have been achieved, and in some key areas the trend lines are moving in the opposite direction. For example, the percentage of eighth graders who have ever used illicit drugs has increased rather than decreased. The number of drug-related deaths and emergency room visits has increased 19 percent rather than decreasing 15 percent as planned. Substantially more Americans now die every year of drug overdoses than in traffic crashes.

Now, it's also important to recognize progress in some key areas. For example, there have been substantial reductions in the use of alcohol and tobacco by eighth graders, and the 30-day prevalence of drug use by teenagers has also dropped.

There has also been recent progress in Federal drug prevention and treatment programs. Two years ago, we found the coordination across 76 Federal programs at 15 Federal agencies was all too often lacking. For example, 40 percent of the programs reported no coordination with other Federal agencies. We recommended that ONDCP take action to reduce the risk of duplication and improve coordination.

Since our report, ONDCP has done just that. It has conducted an inventory of the various programs and updated its budget process and monitoring efforts to enhance coordination.

Another GAO report highlighted the risks of duplication and overlap among various field-based multi-agency entities. To enhance coordination, ONDCP funds and supports multi-agency investigative support centers in HIDTAs. These centers were one of

five information-sharing entities we reviewed, including joint terrorism task forces and urban area fusion centers.

We found that while these entities have distinct missions, roles, and responsibilities, their activities can overlap. For example, 34 of the 37 field-based entities we reviewed conducted overlapping analytical or investigative support activities. We also found that ONDCP and other agencies did not hold field-based entities accountable for coordination or assess opportunities to improve coordination.

Since our report, ONDCP and the Department of Homeland Security have taken actions to address our recommendations. However, they have not yet sufficiently enhanced coordination mechanisms or assessed where practices that enhance coordination, such as serving on one another's governance boards or collocating with other entities, can be applied to reduce overlap.

In conclusion, as Congress considers options for reauthorizing ONDCP, it's worth reflecting on the deeply ingrained nature of illicit drug use in this country. It's an extremely complex problem that involves millions of people, billions of dollars, and thousands of communities. There are very real costs in lives and livelihoods across the U.S. GAO stands ready to help Congress oversee ONDCP and the other Federal agencies as they work to reduce those costs.

Mr. Chairman, thank you for the opportunity to testify today. I look forward to your questions.

[Prepared statement of Mr. Maurer follows:]

GAO Highlights

Highlights of GAO-16-257T, a testimony before the Subcommittee on Government Operations, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

ONDCP is responsible for coordinating the implementation of drug control policy across the federal government and funds HIDTAs that aim to support the disruption and dismantlement of drug-trafficking and money-laundering organizations.

This statement addresses the extent to which ONDCP (1) has achieved Strategy goals and has mechanisms to monitor progress, (2) has assessed overlap and potential duplication across federal drug abuse prevention and treatment programs and identified coordination opportunities, (3) holds HIDTAs accountable for coordination with other field-based information sharing entities and has assessed opportunities for coordination, and (4) has connected existing systems to coordinate law enforcement activities.

This statement is based on a March 2013 report (GAO-13-333), an April 2013 report (GAO-13-471), and selected updates as of November 2015. For the updates, GAO analyzed ONDCP documents on progress toward Strategy goals and drug abuse prevention and treatment programs and contacted ONDCP and HIDTA officials.

What GAO Recommends

GAO has made prior recommendations to ONDCP to assess overlap in drug prevention and treatment programs; develop measures and assess opportunities to enhance coordination of field-based entities; and connect existing coordination systems. ONDCP concurred and reported actions taken or underway to address them. GAO is not making new recommendations in this testimony.

View GAO-16-257T. For more information, contact Dave Maurer at (202) 512-8777 or maurerd@gao.gov.

December 2015

OFFICE OF NATIONAL DRUG CONTROL POLICY

Lack of Progress on Achieving National Strategy Goals

What GAO Found

GAO reported in March 2013 that the Office of National Drug Control Policy (ONDCP) and other agencies had not made progress toward achieving most of the goals in the 2010 National Drug Control Strategy (the Strategy) and ONDCP had established a new mechanism to monitor and assess progress. In the Strategy, ONDCP established seven goals related to reducing illicit drug use and its consequences to be achieved by 2015. As of March 2013, GAO's analysis showed that of the five goals for which primary data on results were available, one showed progress and four showed no progress. GAO also reported that ONDCP established a new monitoring system intended to provide information on progress toward Strategy goals and help identify performance gaps and options for improvement. At that time, the system was still in its early stages, and GAO reported that it could help increase accountability for improving progress. In November 2015, ONDCP issued its annual Strategy and performance report, which assess progress toward all seven goals. The Strategy shows progress in achieving one goal, no progress on three goals, and mixed progress on the other three goals. Overall, none of the goals in the Strategy have been fully achieved.

ONDCP has assessed the extent of overlap and potential for duplication across federal drug abuse prevention and treatment programs and identified opportunities for increased coordination, as GAO recommended in March 2013. According to ONDCP's July 2014 assessment, these programs generally serve distinct beneficiaries in distinct settings, which helps prevent overlap and duplication. However, ONDCP found that programs that provide drug abuse prevention and treatment services to address homelessness would benefit from greater coordination. ONDCP noted that it was taking steps to address this issue.

GAO reported in April 2013 that ONDCP-funded High Intensity Drug Trafficking Area (HIDTA) Investigative Support Centers and four other types of field-based information sharing entities had overlapping analytical and investigative support activities. However, ONDCP and the Departments of Homeland Security (DHS) and Justice (DOJ)—the federal agencies that oversee or provide support to the five types of field-based entities—were not holding entities accountable for coordination or assessing opportunities to implement practices that could enhance coordination, reduce unnecessary overlap, and leverage resources. ONDCP agreed with GAO's recommendations to work with DHS and DOJ to develop measures and assess opportunities to enhance coordination of field-based entities. Since July 2015, the agencies have worked through an interagency committee to make plans for collecting data on field-based collaboration, but have not yet fully addressed GAO's recommendations.

ONDCP has connected each of the systems that HIDTAs use to coordinate law enforcement activities, as GAO recommended in April 2013. Specifically, GAO reported in 2013 that HIDTAs and Regional Information Sharing System centers operated three systems that duplicate the same function—identifying when different law enforcement entities may be conducting a similar enforcement action, such as a raid at the same location—resulting in some inefficiencies. In May 2015, ONDCP completed connecting all three systems, which helps reduce risks to officer safety and potentially lessens the burden on law enforcement agencies that were using multiple systems.

Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee:

I am pleased to be here today to discuss the Office of National Drug Control Policy's (ONDCP) strategic planning efforts related to drug control and coordination of High Intensity Drug Trafficking Area (HIDTA) Investigative Support Centers with other field-based information sharing entities. ONDCP is responsible for, among other things, overseeing and coordinating implementation of national drug control policy across the federal government to address illicit drug use.[1] In this role, ONDCP is required annually to develop a National Drug Control Strategy (the Strategy), which is to set forth a comprehensive plan to reduce illicit drug use through programs intended to prevent or treat drug use or reduce the availability of illegal drugs, as well as to develop a National Drug Control Program Budget proposal for implementing the Strategy.[2] Additionally, ONDCP administers grants to support HIDTAs, which aim to support the disruption and dismantlement of drug-trafficking and money-laundering organizations through the prevention or mitigation of associated criminal activity.[3] While HIDTAs have a distinct mission, the analytic and investigative services they provide can overlap with those of other field-based information sharing entities operated or supported by the Department of Homeland Security (DHS) and the Department of Justice (DOJ), making coordination paramount in leveraging resources and avoiding unnecessary duplication.[4] HIDTAs also operate event deconfliction systems that identify when different law enforcement entities

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

[2]21 U.S.C. §§ 1703(b)-(c), 1705(a).

[3]HIDTA program resources may also be used to assist law enforcement agencies in investigations and activities related to terrorism and the prevention of terrorism.

[4]Other field-based information sharing entities include Joint Terrorism Task Forces, which are funded and supported by DOJ's Federal Bureau of Investigation (FBI); Field Intelligence Groups, which are part of the FBI; Regional Information Sharing System (RISS) centers, which are funded through grants administered by DOJ, and state and major urban area fusion centers, which are state and locally-owned but funded and supported, in part, by DHS.

may be conducting similar enforcement actions, such as a raid at the same location, to help ensure officer safety.[5]

ONDCP reported that about $26.3 billion was provided for drug control programs in fiscal year 2015, and coordination of these programs remains an important step in insuring the effectiveness of these funds. Today, I will discuss the extent to which (1) progress has been made toward achieving National Drug Control Strategy goals and ONDCP has mechanisms in place to monitor progress, (2) ONDCP has assessed the extent of overlap and potential duplication across federal drug abuse prevention and treatment programs and identified coordination opportunities, (3) ONDCP holds HIDTAs accountable for coordination with other field-based information sharing entities and has assessed opportunities for coordination to reduce overlap and duplication, and (4) ONDCP has achieved interoperability among existing deconfliction systems.[6] My remarks today are based on findings from our March 2013 report on ONDCP program coordination and our April 2013 report on field-based information sharing, and the status of ONDCP efforts to address related recommendations.[7]

In performing the work for our March 2013 report, we analyzed the 2010 National Drug Control Strategy and its annual updates, available data on progress toward achieving Strategy goals, and documents about ONDCP's monitoring mechanisms. We also analyzed data from questionnaires that we sent to 15 of the 19 federal agencies that administer drug abuse prevention and treatment programs.[8] This survey collected information on services provided and coordination efforts. In

[5]Event deconfliction systems are used to determine when multiple federal, state, or local law enforcement agencies are conducting enforcement actions (e.g., raids, undercover operations, or surveillances) in proximity to one another during a specified time period.

[6]In this context, interoperability refers to the capability of different deconfliction systems to readily connect with one another to enable timely communications.

[7]GAO, *Office of National Drug Control Policy: Office Could Better Identify Opportunities to Increase Program Coordination*, GAO-13-333 (Washington, D.C.: Mar. 26, 2013) and *Information Sharing: Agencies Could Better Coordinate to Reduce Overlap in Field-Based Activities*, GAO-13-471 (Washington, D.C.: Apr. 4, 2013).

[8]We excluded 4 of the agencies included in the fiscal year 2013 National Drug Control Program Budget for varying reasons. For example, we excluded the Centers for Medicare and Medicaid Services because it administers federal health benefit programs that reimburse drug prevention and treatment services but does not directly provide them.

addition, we interviewed officials from ONDCP and selected federal drug control agencies. In performing the work for our April 2013 report, we selected eight urban areas for review where one of each of five types of field-based information sharing entities—HIDTA Investigative Support Centers, Joint Terrorism Task Forces, Federal Bureau of Investigation Field Intelligence Groups, Regional Information Sharing System (RISS) centers, and state and major urban area fusion centers—was either physically located or had jurisdiction and collected information from the entities in those areas on their analytic and investigative support services.[9] We compared the entities' descriptions of their activities and identified overlap among them. We also interviewed ONDCP officials to discuss oversight of the HIDTAs and efforts to achieve interoperability of deconfliction systems used to coordinate investigations. More detail on our scope and methodologies can be found in our March 2013 and April 2013 reports. For updates to these reports, we reviewed ONDCP's summary of its assessment of drug abuse prevention and treatment programs, analyzed ONDCP's reported progress on Strategy goals in its 2015 Strategy and performance report, and contacted ONDCP and HIDTA officials.

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

[9]We also selected the eight urban areas to reflect a range of factors, including variation in risk based on DOJ's 25 Cities Project, colocation of the entities, and geographic dispersion. For DOJ's High-Risk Metropolitan Area Interoperability Assistance Project, DOJ selected 25 cities based on criteria including the perceived risk of a terrorist attack and population size.

Background

ONDCP and Drug Abuse Prevention and Treatment Programs

ONDCP was established by the Anti-Drug Abuse Act of 1988 to, among other things, enhance national drug control planning and coordination and represent the drug policies of the executive branch before Congress.[10] In this role, the office is responsible for (1) developing a national drug control policy, (2) developing and applying specific goals and performance measurements to evaluate the effectiveness of national drug control policy and National Drug Control Program agencies' programs, (3) overseeing and coordinating the implementation of the national drug control policy, and (4) assessing and certifying the adequacy of the budget for National Drug Control Programs.

The 2010 Strategy is the inaugural strategy guiding drug policy under President Obama's administration. For the 2010 Strategy, ONDCP changed its approach from publishing a 1-year Strategy to publishing a 5-year Strategy, which ONDCP is to update annually. The annual updates are to provide an implementation progress report as well as an opportunity to make adjustments to reflect policy changes. ONDCP established two overarching policy goals in the 2010 Strategy for (1) curtailing illicit drug consumption and (2) improving public health by reducing the consequences of drug abuse, and seven subgoals under them that delineate specific quantitative outcomes to be achieved by 2015, such as reducing drug-induced deaths by 15 percent.[11] To support the achievement of these two policy goals and seven subgoals (collectively referred to as goals), the Strategy and annual updates include seven strategic objectives and multiple action items under each objective, with lead and participating agencies designated for each action item.

[10]See 21 U.S.C. § 1702. ONDCP was created and authorized through January 21, 1994, by the National Narcotics Leadership Act of 1988, which was enacted as title 1 of the Anti-Drug Abuse Act of 1988. Pub. L. No. 100-690, 102 Stat. 4181 (1988). ONDCP has continued to operate since the conclusion of its first authorization through multiple reauthorizations or as a result of legislation providing continued funding.

[11]When developing the Strategy, ONDCP identified data sources for each of the seven subgoals, such as the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health.

ONDCP reported that about $25.2 billion was provided for drug control programs in fiscal year 2012. Of this, $10.1 billion, or 40 percent, was allocated to drug abuse prevention and treatment programs.[12] The 15 federal departments, agencies, and components (collectively referred to as agencies) we selected for our review of drug abuse prevention and treatment programs collectively allocated about $4.5 billion in fiscal year 2012 to such programs.[13] These agencies included the Substance Abuse and Mental Health Services Administration, Department of Education, Department of Housing and Urban Development, National Highway Traffic Safety Administration, Office of Justice Programs, and Bureau of Prisons, among others.

HIDTA Investigative Support Centers

The HIDTA program was established in 1988 and is a federally funded program administered by ONDCP that brings together federal, state, and local law enforcement agencies into task forces that conduct investigations of drug-trafficking organizations in designated areas.[14] The HIDTA program is focused on counternarcotics. However, HIDTA program resources may also be used for other purposes such as to assist law enforcement agencies in investigations and activities related to terrorism and the prevention of terrorism.[15] There are 28 HIDTAs across the United States, and each has an Investigative Support Center that serves to support the HIDTA program by providing analytical case

[12]These programs are intended, in all or in part, to prevent the initiation of illicit drug use or treat the abuse, or problematic use, of illicit drugs and provide or fund such services as outreach efforts to discourage first-time drug use and assessment and intervention to assist regular users to become drug-free. The remaining $15.1 billion was allocated to domestic law enforcement, interdiction, and other programs intended to reduce the availability of illegal drugs.

[13]As discussed earlier, we excluded Centers for Medicare and Medicaid Services, which accounted for almost $4.5 billion of the $10.1 billion allocated to prevention and treatment programs in fiscal year 2012.

[14]The Anti-Drug Abuse Act of 1988 established ONDCP and authorized the designation of any specified area of the United States as a high intensity drug trafficking area. See Pub. L. No. 100-690, § 1005(c), 102 Stat. at 4186-87. The Office of National Drug Control Policy Reauthorization Act of 1998 subsequently established the HIDTA program. See Pub. L. No. 105-277, tit. VII, § 707, 2681, 2681-686-87 (1998) (codified as amended at 21 U.S.C. § 1706).

[15]See 21 U.S.C. § 1706(g).

support, promoting officer safety, preparing and issuing drug threat assessments, and developing and disseminating intelligence products.[16]

The HIDTA and RISS programs operate three separate systems that have (1) event deconfliction functions to determine when multiple federal, state, or local law enforcement agencies are conducting enforcement actions—such as raids, undercover operations, or surveillances—in proximity to one another during a specified time period, or (2) target deconfliction functions, which determine if multiple law enforcement agencies are investigating, for example, the same person, vehicle, weapon, or business. Individual HIDTAs have used the Secure Automated Fast Event Tracking Network (SAFETNet) system, which has had event deconfliction functions, among other functions, since 2001 to help ensure officer safety. In 2009, the HIDTA program introduced deconfliction features into the Case Explorer system that differed from SAFETNet by providing a free service that is tied to its performance management process. In 2009, RISS developed RISSafe to provide event deconfliction to its members and those not being served by another system.

GAO Work on Fragmentation, Overlap, and Duplication

Pursuant to federal legislation enacted in 2010, we conduct routine investigations to identify programs, agencies, offices, and initiatives with duplicative goals and activities within departments and government-wide and report annually to Congress.[17] In March 2011 and February 2012, we issued our first two annual reports to Congress in response to this requirement.[18] On the basis of the framework established in these reports, we used the following definitions for assessing drug abuse

[16]In 2013, there were 32 HIDTA Investigative Support Centers—1 in 27 of the 28 HIDTAs, in addition to the Southwest Border HIDTA, which has a center for each of its five regions: Arizona, California, New Mexico, South Texas, and West Texas.

[17]See Pub. L. No. 111-139, § 21, 124 Stat. 8, 29-30 (2010); 31 U.S.C. § 712 Note. See GAO, *2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, GAO-15-404SP (Washington, D.C.: Apr. 14, 2015) for our most recent annual report.

[18]GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO-11-318SP (Washington, D.C.: Mar. 1, 2011), and *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, GAO-12-342SP (Washington, D.C.: Feb. 28, 2012).

prevention and treatment programs and field-based information sharing entities:

- Fragmentation occurs when more than one federal agency (or more than one organization within an agency) is involved in the same broad area of national interest.
- Overlap occurs when fragmented agencies or programs have similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries.
- Duplication occurs when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries.

ONDCP and Other Federal Agencies Have Not Achieved 2010 Strategy Goals; ONDCP Has Established a Mechanism to Monitor Progress

Our 2013 Analysis Found Lack of Progress toward Achieving National Strategy Goals; ONDCP's 2015 National Strategy Shows Progress Still Needed

In our March 2013 report, we found that ONDCP and other federal agencies had not made progress toward achieving most of the goals articulated in the 2010 National Drug Control Strategy. In the Strategy, ONDCP established seven goals related to reducing illicit drug use and its consequences by 2015. As we reported in March 2013, our analysis showed that of the five goals for which primary data on results were available, one showed progress and four showed either no change or movement away from the 2015 goals. For example, no progress had been made on the goal to reduce drug use among 12- to 17-year-olds by 15 percent. According to the data source for this measure—the National Survey on Drug Use and Health—this was primarily due to an increase in the rate of reported marijuana use, offset by decreases in the rates of reported use of other drugs. Table 1 shows 2010 Strategy goals and progress toward meeting them, as of March 2013.

Table 1: 2010 National Drug Control Strategy Goals and Progress toward Meeting Them, as of March 2013

2010 Strategy goals	2009 (baseline)	2010 (new Strategy)	2011	2012	2015 (goal)[a]	Progress from baseline to goal
Curtail illicit drug consumption in America						
1. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent	10.1%	10.1%	10.1%		8.6%	No change
2. Decrease the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco by 15 percent						
Illicit drugs	19.9%	21.4%	20.1%	18.5%	16.9%	Movement toward goal
Alcohol	36.6%	35.8%	33.1%	29.5%	31.1%	Met goal
Tobacco	20.1%	20.0%	18.4%	15.5%	17.1%	Met goal
3. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10 percent	21.4%	21.6%	21.4%		19.3%	No change
4. Reduce the number of chronic drug users by 15 percent[b]						No data available
Improve the public health and public safety of the American people by reducing the consequences of drug abuse						
5. Reduce drug-induced deaths by 15 percent	39,147	40,393			33,275	Movement away from goal[c]
6. Reduce drug-related morbidity by 15 percent						
Emergency room visits for drug misuse and abuse	2,070,451	2,301,050			1,759,883	Movement away from goal
HIV infections attributable to drug use	5,300	5,500			4,505	Movement away from goal
7. Reduce the prevalence of drugged driving by 10 percent[d]	16.3% (2007)				14.7%	No data available

Source: GAO analysis of data from the following sources for these measures: (1) Substance Abuse and Mental Health Administration's (SAMHSA) National Survey on Drug Use and Health, (2) National Institute of Drug Abuse's Monitoring the Future, (3) What America's Users Spend on Illegal Drugs, (4) Centers for Disease Control and Prevention's National Vital Statistics System, (5) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits, (6) Centers for Disease Control and Prevention data on HIV infections attributable to drug use, and (7) National Highway Traffic Safety Administration's National Roadside Survey. | GAO-16-257T

[a]Goals for 2015 were established by calculating 10 to 15 percent decreases, as applicable, from the 2009 baselines.

[b]The data source for this measure is a report entitled *What America's Users Spend on Illegal Drugs*, which is sponsored by the Office of National Drug Control Policy (ONDCP). As of March 2013, the most recent report had been released in June 2012 and provided data from 1998 through 2006. We reported that, according to ONDCP officials, the baseline for this measure will be established when updated results through 2010 are available in May 2013.

[c]Strategy goals call for decreases in the prevalence or numbers of drug use, drug users, or consequences of drug use. Movement away from goals indicates that the results for these measures have increased from the 2009 baseline or are trending in the opposite direction of the 2015 goals.

[d]In March 2013, we reported that according to ONDCP officials, the primary data source for this measure is the National Roadside Survey conducted by the National Highway Traffic Safety Administration. At that time, the most recent survey in 2007 was the first to include an estimate of the

prevalence of drugged driving. It found that 16.3 percent of weekend, nighttime drivers tested positive for the presence of at least one illicit drug or medication (with the ability to impair). As of March 2013, results of the next survey were expected in 2014. Accordingly, ONDCP officials stated that 2007 is the baseline year for this measure. These officials said that SAMHSA's National Survey on Drug Use and Health, which also measures the prevalence of drugged driving, serves as a secondary data source to the National Roadside Survey.

We reported in March 2013 that, according to ONDCP officials, a variety of factors could affect achievement of these goals, such as worsening economic conditions, changing demographics, or changing social or political environments; the passage of state laws that decriminalize marijuana use or allow its use for medical purposes; failure to obtain sufficient resources to address drug control problems; insufficient commitment from agency partners; and the need for new action items that include initiatives or activities beyond those that are under way or planned. We reported that ONDCP officials stated that the office's new Performance Reporting System (PRS) is to provide more specific information about where the Strategy is on or off track and prompt diagnostic reviews to identify causal factors contributing to any problems identified, as discussed below.

ONDCP released the 2015 Strategy on November 17, 2015, and it is an annual update to the 2010 Strategy.[19] Since our March 2013 report, ONDCP has begun reporting progress toward two goals where data were not initially available. According to data available to date, the Strategy shows progress toward achieving one goal, no progress on three goals, and mixed progress on the remaining three goals. Overall, none of the goals in the 2010 Strategy have been fully achieved. Table 2 shows the 2010 Strategy goals and ONDCP's reported progress toward meeting them.

[19]Executive Office of the President, Office of National Drug Control Policy, *National Drug Control Strategy* (Washington D.C.: 2015).

Table 2: 2010 National Drug Control Strategy Goals and the Office of National Drug Control Policy's (ONDCP) Reported Progress toward Meeting Them, as of November 2015

2010 Strategy goals	2009 (baseline)	Progress to date[a]	2015 (goal)
Curtail illicit drug consumption in America			
1. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent	10.1%	8.8% (2013)	8.6%
2. Decrease the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco by 15 percent			
Illicit drugs	19.9%	20.3% (2014)	16.9%
Alcohol	36.6%	26.8% (2014)	31.1%
Tobacco	20.1%	13.5% (2014)	17.1%
3. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10 percent	21.4%	21.5% (2013)	19.3%
4. Reduce the number of chronic drug users by 15 percent[c]			
Cocaine	2.7 million	2.5 million (2010)	2.3 million
Heroin	1.5 million	1.5 million (2010)	1.3 million
Marijuana	16.2 million	17.6 million (2010)	13.8 million
Methamphetamine	1.8 million	1.6 million (2010)	1.5 million
Improve the public health and public safety of the American people by reducing the consequences of drug abuse			
5. Reduce drug-induced deaths by 15 percent	39,147	46,471 (2013)	33,275
6. Reduce drug-related morbidity by 15 percent			
Emergency room visits for drug misuse and abuse	2,070,452	2,462,948 (2011)	1,759,884
HIV infections attributable to drug use[a]	5,799	4,366 (2013)	4,929
7. Reduce the prevalence of drugged driving by 10 percent[b]	16.3% (2007)	20.0% (2013)	14.7%

Source: GAO analysis of ONDCP's 2015 *National Drug Control Strategy* and Performance Reporting System | GAO-16-257T

[a]Years for which the most recent data were available are in parentheses.

[b]According to the 2015 Performance Reporting System (PRS) report, the data source for this measure has been changed from cases of incidence of drug-related HIV to diagnoses of such cases, because the estimation of the incident cases is not expected to be produced in time to be useful in assessing progress toward achieving this measure.

[c]The primary data source for this measure is the National Roadside Survey, conducted by the National Highway Traffic Safety Administration. The baseline survey was conducted in 2007. The Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, which also measures the prevalence of drugged driving, serves as a secondary data source to the National Roadside Survey. The 2015 PRS report shows the drugged driving goal being met when this data source is used.

ONDCP Established a System to Monitor Progress toward Goals

In March 2013, we reported that ONDCP established the PRS to monitor and assess progress toward meeting Strategy goals and objectives and issued a report (the PRS report) describing the system with the 2012 Strategy update. The PRS includes interagency performance measures

and targets under each Strategy objective. For example, 1 of the 6 performance measures under the objective to strengthen efforts to prevent drug use in our communities is the average age of initiation for all illicit drug use, which has a 2009 baseline of 17.6 years of age and a 2015 target of 19.5 years of age. According to the PRS report, system information is to be used to inform budget formulation and resource allocation, Strategy implementation, and policy making, among other things.

As part of our review, we assessed PRS measures and found them to be generally consistent with attributes of effective performance management identified in our prior work as important for ensuring performance measures demonstrate results and are useful for decision making.[20] For example, we found that the PRS measures are clearly stated, with descriptions included in the 2012 PRS report, and all 26 of them have or are to have measurable numerical targets. In addition, the measures were developed with input from stakeholders through an interagency working group process, which included participation by the Departments of Education, Justice, and Health and Human Services, among others. The groups assessed the validity of the measures and evaluated data sources, among other things.

We reported in March 2013 that, according to ONDCP officials, information collected through the PRS is to provide valuable insights to help identify where the Strategy is on track and when further problem solving and evaluation are needed. At that time, the system was still in its early stages and ONDCP had not issued its first report on the results of the system's performance measures. Accordingly, operational information was not available to evaluate the system's results. ONDCP officials stated that when results are determined to not be on track to meet 2015 targets, the PRS is to serve as a trigger for an interagency review of potential causes of performance gaps and options for improvement. We reported that, according to these officials, ONDCP plans to assess the effectiveness of the PRS more comprehensively to determine how well it is working and whether any adjustments need to be made after the system has been operational for a longer period of time. We also reported that these plans should help increase accountability for improving results

[20]See GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Season Performance Measures*, GAO-03-143 (Washington, D.C.: Nov. 22, 2002).

and enhance the system's effectiveness as a mechanism to monitor progress toward Strategy goals and objectives and assess where further action is needed to improve progress.

ONDCP released its annual PRS report on November 17, 2015. The 2015 report assesses progress on the Strategy's goals, as well as performance measures related to each of the Strategy's objectives, and discusses future actions required to achieve these goals and measures.

ONDCP Has Assessed the Extent of Overlap and Duplication across Federal Drug Abuse Prevention and Treatment Programs and Identified Opportunities for More Coordination

ONDCP has assessed the extent of overlap and potential for duplication across federal drug abuse prevention and treatment programs and identified opportunities for increased coordination, as we recommended in March 2013. Specifically, we reported that drug abuse prevention and treatment programs were fragmented across 15 federal agencies that funded or administered 76 programs in fiscal year 2011, and identified overlap in 59 of these programs because they can provide or fund at least one drug abuse prevention or treatment service that at least 1 other program can provide or fund, either to similar population groups or to reach similar program goals. For example, 6 programs reported that they can provide or fund drug abuse prevention services for students and youth in order to support program goals of preventing drug use and abuse among young people. All 6 of these programs also reported that they can provide or fund services to conduct outreach and educate youth on drug use.

As part of our review, we also conducted a more in-depth analysis in two selected areas where we identified overlap—programs for youth and programs for offenders. We reported that agency officials who administer programs in these two areas took various efforts to coordinate overlapping programs or services, which can serve to minimize the risk of duplication. For example, using an interagency agreement, the Department of Education jointly administers the Safe Schools/Healthy Students program with the Departments of Justice and Health and Human Services to provide complementary educational, mental health, and law enforcement services to prevent youth violence and drug use.

We found in March 2013 that although the agencies' coordination efforts in these two areas were consistent with practices that we had previously reported federal agencies use to implement collaborative efforts, not all of

the programs surveyed were involved in coordination efforts with other federal agencies.[21] Specifically, officials from 29 of the 76 (about 40 percent) programs surveyed reported no coordination with other federal agencies on drug abuse prevention or treatment activities in the year prior to our survey. Furthermore, we reported that although ONDCP coordinates efforts to develop and implement the Strategy and National Drug Control Program Budget, it had not systematically assessed drug abuse prevention and treatment programs to examine the extent of overlap and potential for duplication and identify opportunities for greater coordination. As a result, we recommended that ONDCP conduct such an assessment.

ONDCP concurred with our recommendation and has implemented it. In July 2014, ONDCP published an assessment of drug abuse prevention and treatment programs in its fiscal year 2015 Budget and Performance Summary, which was released with the annual Strategy. ONDCP reported that it conducted this assessment by (1) preparing an inventory of federal agency drug abuse prevention and treatment program activities, starting with those in our report; (2) mapping the beneficiaries and services provided by each program activity to determine the extent of overlap; and (3) reviewing overlapping programs to assess the level of coordination activities, among other steps. The assessment found that these programs generally serve distinct beneficiaries in distinct settings, which helps prevent overlap and duplication. In the cases where overlap could occur, ONDCP's review of grant awards made under the programs determined that duplication did not occur over a 3-year period ending in 2013. Further, according to the assessment, the agencies managing overlapping programs have coordinated through interagency collaboration, coordinated grant applications, and other activities. However, ONDCP found that programs that provide drug abuse prevention and treatment services to support efforts to address homelessness would benefit from greater coordination. In August 2014, ONDCP stated that it is working to ensure additional coordination in this area by, for example, providing guidance to relevant agencies during the office's budget and oversight review process on improving coordination of grant programs that offer similar treatment and recovery support services to homeless clients.

[21]See GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, GAO-12-1022 (Washington, D.C.: Sept. 27, 2012).

ONDCP's assessment states that the office will continue to monitor the programs that overlap, as well as any new federal programs that are added to prevent and treat substance use disorders. According to the assessment, this monitoring is to include requiring regular reporting from the agencies as a part of interagency prevention and treatment working group meetings and working with the agencies to ensure greater coordination and opportunities to consolidate programs as a part of the annual budget process. As a result of ONDCP's actions in response to our recommendation, the office will be better positioned to help ensure that federal agencies undertaking similar prevention and treatment efforts better leverage and more efficiently use limited resources.

ONDCP Does Not Hold HIDTAs Accountable for Coordination and Has Not Assessed Opportunities to Help Reduce Potential Overlap

Our April 2013 report found that ONDCP, DHS, and DOJ did not hold HIDTAs or the four other types of field-based information sharing entities we reviewed—Joint Terrorism Task Forces, Federal Bureau of Investigation Field Intelligence Groups, RISS centers, and state and major urban area fusion centers—accountable for coordinating with one another or assessing opportunities for further enhancing coordination to help reduce the potential for overlap and achieve efficiencies. Specifically, we found that while the five types of field-based entities have distinct missions, roles, and responsibilities, their activities can overlap.[22] For example, across the eight urban areas that we reviewed, we identified 91 instances of overlap in some analytical activities—such as producing intelligence reports—and 32 instances of overlap in investigative support activities, such as identifying links between criminal organizations. These entities conducted similar activities within the same mission area, such as counterterrorism, and for similar customers, such as federal or state agencies. Across the eight urban areas, 34 of the 37 field-based entities we reviewed conducted an analytical or investigative support activity that overlapped with that of another entity. We reported that this can lead to benefits, such as the corroboration of information, but may also burden customers with redundant information.

In our April 2013 report, ONDCP, DHS, and DOJ officials acknowledged that field-based entities working together and sharing information are important, but they do not hold their entities accountable for such

[22]In general, HIDTA Investigative Support Centers focus on narcotics-related matters and support HIDTA drug task force initiatives in their respective areas in the identification, targeting, arrest, and prosecution of key members of criminal drug organizations.

coordination. For example, HIDTA Investigative Support Centers have a performance measurement program that holds the centers accountable for referring leads to other HIDTAs and other agencies, but the program does not include measures about the HIDTA's ability to coordinate with other field-based entities. Further, ONDCP, DHS, and DOJ officials stated that they ultimately rely on the leadership of their respective field-based entities to ensure that successful coordination is occurring because the leaders in these entities are most familiar with the other stakeholders and issues in their areas, and are best suited to develop working relationships with one another.

Officials at 22 of the 37 entities we reviewed agreed that successful coordination depends most on personal relationships, but they noted that coordination can be disrupted when new leadership takes over at an entity. Officials at 20 of the 37 entities also stated that measuring and monitoring coordination could alleviate the process of starting over when new personnel take over at a partner entity and ensure that maintaining coordinated efforts is a priority. We concluded that a mechanism—such as performance metrics—that holds entities accountable for coordination and enables agencies to monitor and evaluate the results of their efforts could help provide the agencies with information on the effectiveness of coordination among field-based entities and help reduce any unnecessary overlap in entities' efforts. We recommended that the agencies collaborate to develop such a mechanism.

Similarly, our April 2013 report found that ONDCP, DHS, and DOJ had not assessed opportunities to implement practices that were identified as enhancing coordination. Officials at each of the 37 entities in the eight urban areas we reviewed described how practices such as serving on one another's governance boards or, in some cases, colocating with other entities allowed or could allow them to achieve certain benefits. These include better understanding the missions and activities of the other entities, coordinating the production of analytical products, and sharing resources such as subject matter experts. In their view, this helped to increase coordination, leverage resources, and avoid or reduce the negative effects of unnecessary overlap and duplication in their analytical, tactical, and dissemination activities. We recommended that the agencies collaborate to perform a collective assessment of where these and other practices that can enhance coordination could be implemented.

ONDCP and DHS concurred with both of our recommendations and DOJ generally agreed with the intent of the recommendations. Since our April 2013 report, the agencies have taken steps to address them. Specifically,

ONDCP, DHS, and DOJ have existing forums they can use to work together in developing metrics and conducting assessments to better ensure coordination, and collectively monitor and evaluate results achieved. These forums include, for example, the Fusion Center Subcommittee of the Information Sharing and Access Interagency Policy Committee.[23] In July 2015, the subcommittee met and agreed to modify its 2015 work plan to address the collection, analysis, and reporting of data pertaining to field-based information sharing entities. According to DHS officials, these data are to focus on field-based collaboration, including governance, colocation, and other information sharing, analytic, and conflict-avoidance topics. Since the July 2015 meeting, DHS has assisted ONDCP and DOJ in developing an assessment template, based on common data elements it collects in its annual assessment of state and major urban area fusion centers.

Although ONDCP, DHS, and DOJ have taken actions to address our recommendations, the agencies do not yet have a collective mechanism that will hold field-based entities accountable for coordinating with one another and allow the agencies to monitor progress and evaluate results across entities. Such a mechanism could help entities maintain effective relationships when new leadership is assigned and avoid unnecessary overlap in activities, which can also help entities to leverage scarce resources. Further, the agencies have not conducted a collaborative assessment of where practices that enhance coordination can be applied to reduce overlap, collaborate, and leverage resources for their respective field-based information sharing entities. Such an assessment would allow the agencies to provide recommendations or guidance to the entities on implementing these practices.

[23]The Information Sharing and Access Interagency Policy Committee is led out of the Executive Office of the President.

ONDCP Has Connected the Systems That Deconflict Operations, Reducing Risks to Officer Safety and Inefficiencies

ONDCP has connected each of the systems that HIDTAs use to deconflict operations, an action that can reduce risks to officer safety and inefficiencies. Our April 2013 report found that the HIDTA and RISS programs operate three separate systems that have event or target deconfliction functions to determine when multiple federal, state, or local law enforcement agencies are conducting enforcement actions—such as raids, undercover operations, or surveillances—in proximity to one another during a specified time period. As we reported in 2013, HIDTAs have used the SAFETNet system, which has had event deconfliction functions, among other functions, since 2001 to help ensure officer safety. In 2009, the HIDTA program introduced deconfliction features into the Case Explorer system that differed from SAFETNet by providing a free service that is tied to its performance management process.[24] In 2009, the RISS program developed RISSafe to provide event deconfliction to its members and those not being served by another system. Accordingly, HIDTAs and RISS centers were operating duplicative deconfliction systems—that is, systems that aim to ensure that law enforcement officers are not conducting enforcement actions at the same time in the same place or investigating the same target—which could pose risks to officer safety and lead to inefficiencies. Table 3 provides details about the features of these three systems.

[24]Case Explorer is a web-based law enforcement software program that includes event deconfliction as well as case management and target deconfliction.

Table 3: Systems with Deconfliction Functions That RISS Centers and HIDTAs Operate

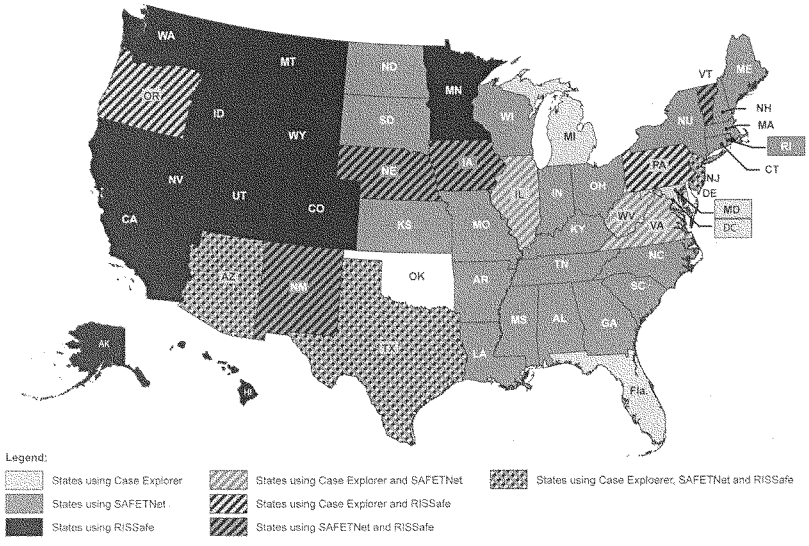
	RISS-operated	HIDTA-operated	
	RISSafe	Case Explorer	SAFETNet
Type of deconfliction			
Event	√	√	√
Target			√
Features			
Open to law enforcement and criminal justice agencies	√	√	√
Manages information about people, places, and vehicles	√	√	√
Operates a watch center to put law enforcement agents in contact with one another	√	√	√
Direct entry/24-hour access	√	√	√
Plots events geospatially, notifying the user of any conflicts within a defined radius	√	√	√
Can enter only future events	√	√	

Source: GAO analysis of ONDCP and RISS information. | GAO-15-257T

Note: While HIDTAs operate two of the systems, individual HIDTAs can use any or all of the three systems.

Law enforcement officers generally enter events into a deconfliction system electronically or by calling a watch center. Individuals operating a watch center plot the location of the event on a map and notify the officer for whom contact information is available in the systems of other officers who have entered conflicting events into the same system. When events are not deconflicted, officer safety can be at risk. For example, HIDTA and RISS officials described instances when officers did not deconflict drug busts, which led to undercover officers from different agencies drawing guns on one another thinking the other officers were drug dealers. The officials added that, had the events been deconflicted, the officers would have been aware of one another's presence. As shown in figure 1, entities within a state can use one or more of the systems.

Figure 1: Use of Systems with Event Deconfliction Functions by State as of April 2013



Source: GAO analysis of BJA and HIDTA data; Map Resources (map). | GAO-16-257T

In our April 2013 report, we found that HIDTA and RISS officials had taken steps to connect target deconfliction systems—those that inform agencies when they are investigating the same individuals, weapons, vehicles, or businesses—and two of three event deconfliction systems. However, HIDTA officials had not finalized plans to make the remaining event deconfliction system, SAFETNet, interoperable with the other two systems. Accordingly, we recommended that the Director of ONDCP work with the appropriate HIDTA officials to develop milestones and time frames for actions needed to make SAFETNet interoperable in order to prevent unnecessary delays in reducing risks to officer safety and lessening the burden on law enforcement agencies that are currently using multiple systems to notify agencies when they are conducting

conflicting enforcement actions. ONDCP concurred with the recommendation and, in May 2015, completed the steps to achieve interoperability among the three event deconfliction systems. According to an official at the HIDTA that operates the Case Explorer deconfliction system, as of October 2015, more than 1,500 agencies are participating in the three systems. The official added that more than 159,000 events have been entered, and more than 800 events have been matched among the three systems.

Chairman Meadows, Ranking Member Connolly, and members of the subcommittee, this concludes my prepared statement. I would be happy to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions about this testimony, please contact David Maurer at (202) 512-8777 or maurerd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other contributors included Eric Erdman, Assistant Director; Kevin Heinz; and Johanna Wong.

Mr. MEADOWS. Thank you so much. I appreciate the fact that you acknowledge maybe deficiencies, but also areas where performance was good. So thank you for that balanced testimony.

The chair is going to recognize the vice chair of the subcommittee, Mr. Walberg, for his 5 minutes of questioning.

Mr. WALBERG. Thank you, Mr. Chairman. I appreciate that and enjoyed my time in your district over Thanksgiving. I'm notifying you of that now since you don't have a chance to call the sheriff.

Back to serious. Like many areas across the country, the communities in my district, Mahnomen County right on the Toledo line and others, have experienced some significant struggles in fighting against the growing tide of heroin use and abuse and also the misuse of medication, prescription pain medicines as well.

I'm aware that ONDCP has increased some of their efforts in this area, specifically through the Heroin Response Strategy. Unfortunately, this program is limited to certain regional areas.

Mr. Botticelli, what efforts has ONDCP undertaken to address prescription drug abuse and heroin use?

Mr. BOTTICELLI. Sure. Thank you, Congressman, for that question. And I think there's no more pressing issue that faces ONDCP and the country right now than the morbidity and mortality associated with prescription drugs and heroin.

You know, part of the work that ONDCP does is continuing to monitor these drug trends and make sure that we are putting resources and efforts against those. In 2011, ONDCP released a prescription drug abuse plan acknowledging the role that particularly prescription drugs were playing at the time as it relates to some of these issues. These included broad-based efforts to reduce the prescribing of these prescription medications, to call for State-based prescription drug monitoring programs so that physicians would have access to patients' prescribing histories, to look, working with our partners at the DEA, to reduce the supply of drugs coming from many of these communities, and to also coordinate law enforcement actions.

We also simultaneously called for an increase in resources, particularly treatment resources, to deal with the demand that we've seen for those resources.

And we've made some progress in those areas. We've seen reductions in prescription drug misuse among youth and young adults. We've seen a leveling off of prescription drug overdoses over the past several years. Unfortunately, however, that's been replaced by significant increases in heroin-related overdose deaths.

Mr. WALBERG. Is that simply where they're going because of reduced cost to them, accessibility, and other reasons?

Mr. BOTTICELLI. So when we look at data, it appears that only a very small portion of people who have misused prescription drugs actually progress to heroin, about 5 percent. But if you look at newer users to heroin, 80 percent of them started misusing pain medication. So we know to deal with the heroin crisis compels us to deal with the prescription drug use issue.

But we're also focusing on how we address the heroin issue, again from a comprehensive perspective. We know that some of this is related to the vast supply of very cheap, very pure heroin, in parts of the country where we haven't seen it before. As Con-

gressman Cummings talked about, we know that heroin has been in many of our communities for a long time, but we really have to diminish the supply that we have.

But we also have to treat it, make sure that people have access to good evidence-based care. And we've also been working, quite honestly, in our partners with law enforcement to diminish and reduce overdoses through the overdose reversal drug Naloxone.

And, you know, I have to say I've been really heartened by how law enforcement across this country has taken on not only reversing drug overdoses, but also to the point of not arresting people, are shepherding people into treatment. So not only have we seen our law enforcement entities respond in terms of reducing overdoses, but are really accelerating and coming up with what I think are really innovative programs to get people into treatment.

Mr. WALBERG. Okay. Thank you.

So, Mr. Kelley, what efforts has the HIDTA program undertaken to address prescription drug abuse and heroin use, following up with what Director Botticelli said?

Mr. KELLEY. Sure. And thank you for that question.

The HIDTA program has historically always identified the most prevalent threat. There is no greater threat, certainly in the Northeast, but throughout other areas of the country, than the abuse of heroin and controlled prescription drugs. It is probably the overriding issue taking the lives of so many. So for that reason, the HIDTA program has put that firmly on the radar.

The HIDTA program, through its enforcement efforts of Federal, State, and local at the ground level, comprised of Federal agencies, State, and local working together to identify, number one, the source of the heroin that's coming into this country, dealing with the drug-trafficking organizations that have literally invaded our communities through a variety of investigative methods.

But the HIDTA program also embraces, as I said earlier, a very holistic and multidisciplinary approach. We recognize in law enforcement across this country each and every day that we can't arrest our way out of this problem. And so for that, we have reached out to the public health community, we have made partnerships where partnerships never were before.

Mr. WALBERG. International as well?

Mr. KELLEY. International as well. International through ONDCP and the DEA, which are probably the backbone of many HIDTAs, have worked to identify where it's coming internationally. And when we do that, we try to interrupt that supply line. The supply line goes to distribution areas throughout the United States. We have HIDTA groups that day in and day out focus primarily, again, on the major trafficking organizations, not the user on the street per se, not the person that's afflicted medically that's the victim of a disease, but by those organizations that are making money at the anguish of so many.

So we look at it in a multidisciplinary approach from enforcement, from prevention, and from partnerships that we've established throughout the public safety and public health community.

Mr. WALBERG. Thank you.

And my time has expired, and thanks for the latitude.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the ranking member of the subcommittee, Mr. Connolly, for 5 minutes.

Mr. CONNOLLY. Mr. Chairman, I would be pleased to defer to the distinguished ranking member of the full committee, Mr. Cummings, if he wishes to go.

Mr. CUMMINGS. Thank you very much.

In trying to tackle drug use from all angles, I understand that ONDCP uses demand-reduction efforts as well as supply reduction efforts. I also understand that ONDCP would like to clarify in the definition section of this new reauthorization that it is demand reduction work can include prevention, treatment, and recovery efforts.

Now, Mr. Botticelli, can you give some examples of what you mean by prevention, treatment, and recovery efforts, briefly?

Mr. BOTTICELLI. Thank you, Congressman.

As you noted, one of the overriding efforts of our office is to restore balance to drug policy, that for too long we have used public safety as our prime response to issues of drug use in many of our communities. And under this administration we've really tried to focus on a balanced portfolio of increasing our demand-reduction efforts and treating this as a public health issue.

Our understanding of addiction has changed dramatically from understanding this just as a criminal justice issue, but as an acute condition and really understanding this as a chronic disease, that one that we can prevent. We've seen some dramatic reductions in underage youth use through our DFC coalitions.

But we also know that many times we have let this disease progress to its most acute condition. And so that's why we're calling for language to allow us to do a better job of screening people and intervening early in their disease before they reach that acute condition and before, quite honestly, they intersect with the criminal justice system.

But we also know that to treat this issue requires more than just acute treatment, that this is a chronic disease that requires long-term recovery. And we know that people need additional supports beyond just treatment, things like housing, employment, peer recovery networks. So part of our language change allows us to focus on that continuum of demand-reduction strategies that we know to be effective in dealing with this as a public health issue.

Mr. CUMMINGS. Now, I understand that ONDCP would like Congress to allow all HIDTAs at the request of their boards to use treatment efforts and to expand their abilities to use prevention efforts. I support this, because 27 of the 28 HIDTAs already understand the importance of using prevention-focused activities. I also support this because I have seen HIDTA treatment efforts work so well in the Baltimore-Washington HIDTA, which is one of the two HIDTAs that currently allows for treatment.

Our Washington-Baltimore HIDTA has provided drug treatment to about 2,000 individuals with criminal records to date, and over half of these have successfully completed their treatment programs. Furthermore, the recidivism arrest rate for these HIDTA clients after 1 year has been just 28 percent, while comparable recidivism rates across many States is over 40 percent.

In addition to the successes I mentioned in my opening statement, the Washington-Baltimore HIDTA has captured over 4,000 fugitives from drug charges and removed over 2,000 firearms from the streets in the last 3 years alone.

So, Mr. Kelley, in your written testimony you noted that the law enforcement community recognizes, "We cannot arrest our way out of this problem." Would you agree that treatment and prevention efforts have augmented the Washington-Baltimore HIDTA's ability to carry out its mission, and how so?

Mr. KELLEY. I would agree with that, Congressman. And how so is that the HIDTA program traditionally has been an enforcement-based program, and that's where our greatest success has lied over the years and continues to show great success from that. But we also recognize as law enforcement professionals that the multidisciplinary, multifaceted approach is so very important as the landscape of drug abuse has changed, that treatment and prevention play crucial roles in the overall strategy. The Washington-Baltimore for many years, and has had treatment programs well before the prohibition was in place, has shown great success.

However, we also recognize that it is a very, very expensive proposition, the treatment end of things. Prevention has been throughout the HIDTA program for a number of years.

The flexibility of the HIDTA program, the beauty of the HIDTA program is our ability to bring people together to make the best possible use of resources, to tap into other treatment sources, to tap into other prevention resources, together with some limited HIDTA funds to make a great impact. I really believe that that can continue should the Congress reauthorize under the current reauthorization language, and I believe that treatment does have a place at the table. I think most HIDTAs across the land, if not all, would agree with that. And the executive board would have that ability to bring that aspect of the strategy into play should they desire to do that.

Mr. CUMMINGS. Now, Mr. Botticelli, other HIDTAs are also using prevention tools like encouraging law enforcement departments to use Naloxone. And I'm very familiar with Naloxone. And one of the things that has concerned me is that they jacked up the prices. The manufacturer, knowing that this is a drug that could save people's lives and has saved people's lives, they jacked up the prices. And I've been all over them, I mean.

And I'm just wondering what efforts have you all—I mean, I know you know this, and I'm wondering, what, if anything, that you all have done to try to encourage the manufacturer of this life-saving drug to be reasonable.

Mr. BOTTICELLI. Thank you for those comments. And I too was very disturbed that the manufacturer decided at this time of great demand to more than triple the price of Naloxone. We know that it diminishes the ability of many of our community-based organizations and law enforcement to really expand this distribution.

You know, we have been pursuing a number of goals. I am pleased to say that just a few weeks ago the FDA approved a new nasal administration developed by another manufacturer. So we hope that that will continue to bring some competition to the marketplace and drive down demand.

We have also looked at establishing part of our work over the past several years of establishing dedicated grant programs either through existing Federal grants or additional dollars to help support the additional purchase of Naloxone because of this lifesaving drug. But it is particularly disconcerting to me, Congressman, that people took advantage of some of the incredible dire need that we have out there to significantly raise the price.

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

And thank you, Mr. Connolly, for yielding.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentleman from South Carolina, Mr. Mulvaney, for 5 minutes.

Mr. MULVANEY. Thank you very much.

Gentlemen, thank you very much for being here today.

I just want to go over a couple of things that Mr. Botticelli said in his opening testimony, Mr. Maurer touched on briefly, and it's in the reports that we have in front of us.

I heard Mr. Botticelli said that they've made substantial or significant progress in the area since 2010, but I heard Mr. Maurer say something a little bit different. So let's drill down into these seven goals.

Mr. Maurer, I couldn't find the seven goals. Could you briefly tell us what they were that the GAO took a look at? You mentioned one of them, which was eighth grade marijuana use, I think, or something like that. But tell us what the seven goals were.

Mr. MAURER. Sure. The seven national goals that were set out in the 2010 strategy were to look at 30-day use by teenagers; eighth grade lifetime drug use, and that was broken down by illicit drugs, alcohol, and tobacco; 30-day use by young adults; the amount of chronic users of different illicit drugs; drug-related deaths; drug-related morbidity; and then rates of drugged driving.

Mr. MULVANEY. All right. And if I read the GAO's summary correctly, here's what I see. Mr. Botticelli, stop me if I'm wrong, and I'll come back and ask you to answer some questions on this. That in March of 2013, the GAO said that, on those seven goals that had been laid out in 2010, that you folks, Mr. Botticelli, had made progress on one, no progress on four, and there appeared to be a lack of data on the other two.

Fast forward to a couple weeks ago when your own analysis came out, and you folks said that you had made progress on one, no progress on three, and what someone described as, "mixed," progress on three others.

So I guess here's my question, guys. It's now 5 years. None of them have been achieved. You've made progress on one, Mr. Botticelli. Tell me, why are we still spending money on this? Why are you all still—why are we still doing this if you've had 5 years and we're, according to Mr. Maurer, we're actually getting worse, not better? So tell me how substantial progress has been made.

Mr. BOTTICELLI. Sure. So let me go over in detail in terms of where our progress is.

Mr. MULVANEY. Sure.

Mr. BOTTICELLI. And I will be happy to have a subsequent conversation with you.

One of the main measures we look at, particularly as it relates to youth, because we know that youth are particularly vulnerable, when we look at the decrease in prevalence, 30-day prevalence rates of drug use among 12 to 17-year-olds, that we have made considerable progress toward those goals that are——

Mr. MULVANEY. Twelve to 17 is the young adult group that he——

Mr. BOTTICELLI. Correct.

Mr. MULVANEY. Okay.

Mr. BOTTICELLI. Correct. And clearly we know that substance use by young adults really can set a lifelong trajectory of pattern.

When we look at eighth graders, because, again, we know that early use predicts lifetime—often predicts lifetime use, when we look at illicit drug use, that's where we have not made progress. And, again, if you take marijuana out from other illicit drugs, that we have made progress, not on marijuana, but on other illicit drug use. But we have met the goals as it's related to alcohol and tobacco use.

Mr. MULVANEY. Let me stop you there and go to Mr. Maurer on this.

Do you agree with that, by the way? If we take marijuana out, have they made substantial progress on the other?

Mr. MAURER. We didn't have access to the root data to allow us to perform that kind of analysis, but it seems to fit with some of the broader trends we've seen in other sources.

Mr. MULVANEY. Okay. Thanks.

Go ahead, Mr. Botticelli.

Mr. BOTTICELLI. So one of the other issues that we look at is chronic users, because we know that these are folks who often have addictive issues, they often are involved in criminal behavior. And when you look at a number of those markers in terms of cocaine use and in terms of methamphetamine use, we've seen significant reductions and we are moving toward our goal.

Marijuana use we're not. We're moving away from that goal. And we've seen a dramatic increase in the chronic use of marijuana, particularly among young adults in this country.

If you look at our marker that looks at reducing drug use among young adults in the country, we've seen no change. But, again, if you take marijuana out of the young adult use, we've seen significant, and actually would have met our target for reducing drug use if it were not for marijuana—increases in marijuana use.

Mr. MULVANEY. Mr. Maurer, if you had the access to that root data and had the ability to separate out marijuana use—and maybe marijuana use is different now than it was in 2010, we've got States legalizing it, decriminalizing it—would it give Congress better data, a better look into what Mr. Botticelli's organization is accomplishing if we could separate out that particular illicit drug?

Mr. MAURER. Absolutely. Access to better data would give better information to inform congressional decisionmaking. We'd be happy to do that.

Mr. MULVANEY. Mr. Botticelli, are you able to do that?

Mr. BOTTICELLI. Yes.

Mr. MULVANEY. Okay.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the ranking member of the subcommittee, Mr. Connolly, for 5 minutes.

Mr. CONNOLLY. I thank the chair.

Mr. Botticelli, Mr. Mulvaney was just asking about metrics. And Mr. Maurer's testimony, I think, left the impression that actually, rather than progress, we're experiencing retrogression. Are we making progress in heroin use in the United States?

Mr. BOTTICELLI. Clearly we are not, sir.

Mr. CONNOLLY. Are we making progress in cocaine use in the United States?

Mr. BOTTICELLI. Yes, we are.

Mr. CONNOLLY. And marijuana, of course, is now in a legal limbo, not at the Federal level, but clearly States are moving away. And I think Mr. Mulvaney's quite right, you need to desegregate that if we're going to have accurate data.

I mean, one of the things about metrics is, and it seems to me that even the seven metrics cited, they're a little bit broad. And we kind of want to dig down, because I think all of us on a bipartisan basis, what we want to do is try to end the drug scourge. Whatever is the most efficacious way to do that, you know, it's what we want too.

One of the concerns I've got, Mr. Kelley—and by the way, where—are you from Boston?

Mr. KELLEY. I'm——

Mr. CONNOLLY. Where are you from?

Mr. KELLEY. I am.

Mr. MEADOWS. We were commenting that the——

Mr. CONNOLLY. If I could have——

Mr. MEADOWS. —the accent is a little bit——

Mr. CONNOLLY. I'll rephrase it. Where are you from?

Mr. KELLEY. Melrose, Massachusetts.

Mr. CONNOLLY. Melrose. All right. Brighton and Allston. I can talk that way if I have to, but I try not to now that I represent Virginia, of course.

Currently, Mr. Kelley, we have in law in the last reauthorization a 5 percent cap on prevention and treatment for your program. Is that correct?

Mr. KELLEY. That's correct.

Mr. CONNOLLY. And the new legislation proposed by the administration would double that to 10 percent. Is that correct?

Mr. KELLEY. It would allow for a—the current language would allow for an amount greater than 5 percent, and the HIDTA Directors is recommending that it be capped at 10 percent.

Mr. CONNOLLY. Effectively capped, but not statutorily capped?

Mr. KELLEY. Not statutorily.

Mr. CONNOLLY. Right.

Mr. KELLEY. It would be a recommendation.

Mr. CONNOLLY. Okay. That's what I was getting at. Because I have a problem with a cap, because any cap is arbitrary, and in any given program you might determine or your colleagues around the country might determine, you know, in this particular case, the prevention and treatment rate is the way to go. And so the mix might be different in South Carolina or North Carolina or Virginia,

and I want to make sure you've got flexibility without diluting the value of the program. Is that the goal you're seeking as well?

Mr. KELLEY. That's exactly right, Congressman. The goal is, is to maintain, to strike that balance, to maintain the integrity of the HIDTA program as we all know it, and the success of the program, as we all know it, which has primarily been enforcement based, disrupting, dismantling drug trafficking organizations aimed at the supply. We also recognize the prevention and treatment aspect of the holistic approach.

So the HIDTA directives, in trying to avoid diluting the program or mission creep, being law enforcement professionals, knowing that there's already a 5 percent, which, I might add, that no HIDTA in the country has approached—in recent memory, has approached 5 percent of this spending on a prevention program, yet they have that ability. We feel that allowing an open-ended spending, or funding for those, has a possibility of changing the structure and integrity of the HIDTA program or a particular HIDTA as we know it.

The strength of the HIDTA program across the Nation, all 28 or 32, depending on the southwest border, how you choose to view it, is its unity in strategy. If we had one or more that really bent a particular way because of open-ended funding, I think it would change the landscape of HIDTA as we know it.

Mr. CONNOLLY. Okay. But your testimony also says we can't arrest our way out of this problem. Let me ask the devil's advocate question: Why not? Why not just arrest anybody who's misusing drugs and just put them where they belong and call it a day? Isn't that a more effective strategy?

Mr. KELLEY. No. Unfortunately, that is not the case. I think——

Mr. CONNOLLY. For everyone watching on C–SPAN, that was a devil's advocate question.

Mr. KELLEY. Right. But it is—no, we can't arrest—there is not enough jails, there are not enough police officers, there are not enough law enforcement officers to do that, number one.

Mr. CONNOLLY. And isn't it also true, Mr. Kelley, that when people do end up in the jail, they get treatment, or they have to get treatment because we can't ignore the problem in jail either?

Mr. KELLEY. We would hope that that would be the case but not always, not always. And sometimes they come out worse than when they went in. And so, I think law enforcement across the land has had a paradigm shift, and they understand, for that very reason, it's kind of a cliche now, we can't arrest our way out of a problem, nor do we want to. They also recognize an addiction is a disease, and needs to be treated.

However, those that capitalize and benefit from that tragedy are the ones we're after.

Mr. CONNOLLY. Final question. You talked about budget reductions from fiscal year 2015. Can you just expand on that and what the impact of those budget reductions have been?

Mr. KELLEY. Well, the HIDTA program is historically—has been very valuable in using the funding that's been appropriated. We have, in the past, provided a very substantial return on investment. To reduce this program would put us back many, many years

in the progress we've made. Certainly, the language in the authorization——

Mr. CONNOLLY. Have we reduced the program?

Mr. KELLEY. Have we reduced it? No, we have not. In fact——

Mr. CONNOLLY. But I thought you talked about a budget reduction from fiscal year 2015. Did I miss that?

Mr. KELLEY. Let me just check.

Mr. CONNOLLY. Mr. Botticelli.

Mr. KELLEY. No, I——

Mr. CONNOLLY. Well, while he's checking, Mr. Botticelli, did you want to—I'm sorry. I'm taking a little more time.

Mr. BOTTICELLI. Sir, thank you for that question. The dollar amount reflected in the reauthorization language was actually taken from the President's fiscal year 2016 budget proposal.

Mr. CONNOLLY. Okay.

Mr. BOTTICELLI. And not representative of level funding of the program.

Mr. CONNOLLY. Mr. Kelley.

Mr. KELLEY. My testimony was, Congressman, is that what the HIDTA directors were recommending, instead of going back, in fiscal year 2015, the HIDTA program, Congress awarded us $245 million, and we've done tremendous things with that money. To go back to 193.4 as—and I know it comes out of appropriations, but in the language of reauthorization in print, should someone decide to latch onto that, would be a 22 percent reduction, it would severely handicap the program.

Mr. CONNOLLY. Thank you. And thank you, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman. The chair recognizes the gentleman from Ohio, Mr. Turner for 5 minutes.

Mr. TURNER. Thank you, Mr. Chairman. I want to follow on to the issues of my good friend, Gerry Connolly, about the issue of incarceration and treatment.

Director Botticelli, I want to thank you for your leadership on this issue of the heroin epidemic, and your visiting with members of the Ohio delegation about its impact in our communities.

As you know, we've discussed that judges and prosecutors in my district have said that upwards of 75 percent of the individuals they arrest or prosecute are suffering with substance abuse or addiction. And you and I have discussed the fact that actually the Federal Government has barriers in place that inhibit an ability for someone who is incarcerated to receive treatment, and I want to talk about two of those with you today and get your thoughts.

The SAMHSA policy, for example, since 1995, the Substance Abuse and Mental Health Services Administration has had a policy in place that prohibits the use of grants from its Center for Substance Abuse Treatment for treating individuals who are incarcerated. Obviously, in this instance, we're not talking about additional resources, just resources being applied to those who are incarcerated.

Our second one is that Medicaid IMD exclusion. Medicaid's institution for mental disease exclusion expressly prohibits reimbursement for services provided to individuals who are incarcerated. Now, these are individuals who are entitled to receive Medicaid, they qualify for Medicaid, and the treatment services that they

would receive are not permitted during the period of incarceration, and one of the things that we know from heroin addiction is it often leads to theft to feed the addiction or other types of criminal activity that results in their incarceration.

Now, I've introduced H.R. 4076, the TREAT Act, which would repeal both of those prohibitions. It would allow SAMHSA money to be used during incarceration for treatment, and also for those individuals who are Medicaid-eligible during their incarceration for Medicaid to be able to reimburse for those expenses for treatment, because as you indicated, Mr. Kelley, people are not receiving treatment once they're incarcerated.

Director Botticelli, I was wondering if you would speak for a moment about those two exclusions of the use of Federal dollars, and whether or not you believe lifting those barriers might help others get treatment?

Mr. BOTTICELLI. Great. Thank you, Congressman. It was a pleasure meeting with the Ohio delegation. I really appreciate your interest in this.

So to your point, first and foremost, we want to divert people away from incarceration in the first place. I expressed to you privately, I saw a really innovative program in Dayton, Ohio, where the police chief is actually holding community forums to get people into care instead of arresting and incarcerating them.

But to your point, for those people who are incarcerated, we do want to ensure that they have good access to high quality treatment. As Mr. Kelley talked about, unfortunately, that takes a tremendous amount of resources, and because of the prohibition on Medicaid, that often goes to the State, either the corrections or the State public health agency, to help support treatment, but unfortunately, too few people have access to them.

So any opportunity that we have to work with Congress to look at how we get additional—how we ensure that people who are incarcerated get good care behind the walls becomes really important, because we know those people come back to our community, and that untreated addiction, when they come back, will just perpetuate the cycle of crime and addiction.

Mr. TURNER. In the SAMHSA policy, same thing, grants that are being made available to communities, and—but they're excluded to be used for those who are incarcerated.

Mr. BOTTICELLI. We'd be happy to work with you because, again, I think, you know, any opportunity that we have to increase the capacity of our jails and prisons, to expand treatment capacity for people behind the walls is a top priority for ONDCP.

Mr. TURNER. Director Botticelli, I appreciate your interest in this.

Mr. Kelley, I appreciate your bringing to focus the issue that there aren't the resources to bring treatment there. Do you have any comments that you want—wish to add?

Mr. KELLEY. No, I—Congressman, I bring those comments because I'm well aware in our area, in New England, we deal with correctional institutes on a fairly frequent basis on a number of issues. I can tell you from my past law enforcement experience, most, if not all, issues that I dealt with had some relation to drugs, a drug abuse, and there were a number of people that I knew per-

sonally that went into the correctional institute, came back out, and within a short period of time, without treatment, they were back committing crimes and back on the addiction. So it is very, very important from a personal standpoint.

Mr. TURNER. Mr. Maurer, do you have comments?

Mr. MAURER. Yeah, we've done some work looking at the Federal prison system at GAO, and the Bureau of Prisons has expanded the amount of resources it spent over the last few years, specifically on drug treatment programs for inmates in the Federal system who are eligible for those programs.

One of the big incentives for inmates to take advantage of those programs is they can have a reduction in the amount of their sentence if they successfully complete those programs.

Mr. TURNER. Thank you.

Mr. MEADOWS. I thank the gentleman for his insightful and well-informed questions, and so the chair now recognizes the gentlewoman from the District of Columbia, my friend, Ms. Norton.

Ms. NORTON. I appreciate this hearing, Mr. Chairman. We've heard—we've heard from Mr. Maurer about the increase in use, and I certainly am not going to blame that on HIDTA or the drug administration, nor does he. In fact, staying ahead of the drug du jour has become such a challenge that I think we ought to concede that it will always be a challenge. If we concede that, then looking into what we can really do would make sense.

I really have a question on the drug du jour in the District of Columbia, synthetic drugs, and another question on marijuana. But we certainly remember when the drug that the entire Nation was focused on was crack cocaine. Now, of course, everybody is focused on opiate and heroin, and it is going to change tomorrow.

I was very interested in Mr. Turner's question about treating people when they are behind bars, because I had a roundtable last night. You know, there are 6,000 Federal returning citizens now all around the country, because of the reduction in the sentence for mandatory minimums.

This was one of the great law and law enforcement American tragedies. We treated crack cocaine differently from cocaine, 100 to 1, and you essentially—or we essentially—by the way, Democrats and Republicans. This was certainly not partisan—essentially destroyed what was left of the African American family. Most of these were black and Latino men in their mid-30's, by the way, right at the prime of life.

All right. So today, you hear about opiates, of course, and heroin, and, well, you might, and about the law enforcement approach that you have been authorized to pursue. But I must ask you, Mr. Botticelli, in light of prevention, I don't see how you can prevent the next drug du jour. I mean, we haven't even brought up the word synthetic drugs yet, but I am cosponsor with several members on the other side of a bill to deal with that new phenomenon. But if—you can't expect law enforcement to prevent new drugs or drugs from changing, I'm not sure why they change.

At the very least, it seems to me, at least my roundtable told me, that once you have somebody, you will often find, as we did when we had these witnesses who had just been released from mandatory minimums, had their mandatory minimum reduced by an av-

erage of 2 years; in questioning them, the length—these, of course, were drug traffickers. They got into drug traffickers by using drugs, and I couldn't help but believe that if somehow treatment had been earlier available, we might have prevented what was one of the worst tragedies in law enforcement in American history, and now we're trying to make up for it.

So you say, okay, shouldn't be 5 percent, should be 10 percent. That has the ring of a number pulled out of the air, because you now have 5 percent because you're flat-funded, and because you don't think you can get anymore. I mean, is that essentially the long and short of it in terms of what is effective, as you now pursue newer and newer drugs every decade, it would appear? Where did you get 10 percent from, especially as a cap?

Mr. KELLEY. Where we got the 10 percent from, Congresswoman, is that was a figure that was derived in two different ways. Number one, using the prevention history of the HIDTA program. Even though that 5 percent of funding has been available for some period of time across the Nation, many HIDTAs have never approached that, and it's not from the lack of——

Ms. NORTON. How about treatment?

Mr. KELLEY. Treatment has never been——

Ms. NORTON. Except in this region we have—because we were grandfathered in.

Mr. KELLEY. You were grandfathered in, correct.

Ms. NORTON. Has the experience that the ranking member spoken about educated you at all about treatment?

Mr. KELLEY. Is that directed to me?

Ms. NORTON. Yeah, to you, or Mr. Botticelli.

Mr. KELLEY. Oh, certainly it has, and, in fact, I speak for all HIDTA directors, when they recognize the value of treatment, most definitely, but——

Ms. NORTON. But how did—I mean, what was the basis for 10 percent?

Mr. KELLEY. 10 percent was based on——

Ms. NORTON. I'm not suggesting another percentage. I'm just suggesting it may not be evidence-based, particularly in light of treatment.

Mr. KELLEY. It was more based on the budget, and the fact of the matter is, is that, historically, we've never exceeded, in the prevention realm, more than 5 percent. I also spoke about the partnership that we have with ONDCP and the fact that we, as law enforcement professionals, value that, and the fact that by elevating it to increasing, almost doubling, that would give the executive boards fairly wide discretion in using an effective baseline.

Now, the baseline of a HIDTA differs across the Nation. Some of those, for example, in New England, HIDTA's baseline is $3.1 million per year. That would allow the executive board, upon approval of the director, to use upwards of $300,000 as a maximum. That is also very important to realize is that that is not the only source of funding for treatment that would be available.

The beauty of the HIDTA program is our partnerships across the spectrum of health care, and in coordinating with other people, we can really maximize that impact. But I think it goes back to allowing for treatment, allowing for prevention, allowing for enforce-

ment, that multi-disciplinary approach is very, very important, and we recognize that, but we also recognize the fact that we are flat-funded across the Nation. Discretionary funding sometimes is—varies, and discretionary funding would allow—the more discretionary funding certainly would allow HIDTAs across the land to use more money for these kinds of programs.

Mr. MEADOWS. All right. I thank the gentlewoman. Thank you, Mr. Kelley, for your response. The chair recognizes the gentleman from Wisconsin, Mr. Grothman, for 5 minutes.

Mr. GROTHMAN. Thank you. I guess I would ask Director Botticelli, how many of people died of heroin overdoses last year in this country?

Mr. BOTTICELLI. Sir, we had over 8,000 people die of heroin overdoses in the United States, and that was data from 2013.

Mr. GROTHMAN. I think that's a lot higher. You're sure it's only 8,000?

Mr. BOTTICELLI. That's the best available data that we have. I think there has been some estimation that because of—because of the information variability that comes from medical examiners and coroners, that that might be underreported, but that's the best available data that we have.

Mr. GROTHMAN. And when I just look at—because when I get around my district, I talk to my sheriffs, how many people died in your county last year of heroin overdoses, and I don't—I don't really think of Wisconsin as being the heroin center of the world, and I'm telling you, when I multiply it out, you know, by counties or by population, it would be higher than that by a factor of, you know, three times or something. Are you sure it's only 8,000, even close to 8,000?

Mr. BOTTICELLI. Let me just say that this is 2013 data, that we expect in the next few weeks to have 2014 data available. Based on my conversations and my travels around the country and what I've heard as well, I would highly anticipate that the number of heroin-associated deaths is far higher than that 8,000.

Mr. GROTHMAN. How do you—I mean, that just bothers me off the top of a bunch of other questions, but I mean, how are you getting that data? Is every county reporting? I mean, is that comprehensive, or do different counties have different ways of reporting? You think 8,000?

Mr. BOTTICELLI. So the way that the reporting works is that county medical examiners, or coroners, report that data to the State and to the Federal level. You know, as I've indicated, there is probably wide variability and the reliability of that reporting——

Mr. GROTHMAN. Yeah.

Mr. BOTTICELLI. —about what goes on those death certificates. We've been actually trying to work at enhancing the quality of our data, but again, this is 2013 data.

Mr. GROTHMAN. Okay. Maybe I can help you with that.

Mr. BOTTICELLI. Okay.

Mr. GROTHMAN. Why don't you get me the data for Wisconsin——

Mr. BOTTICELLI. Sure.

Mr. GROTHMAN. —and then I can tell you the Wisconsin data is accurate, and we get a clue as to whether you're right or wrong.

Second question. Where is this heroin coming from?

Mr. BOTTICELLI. So we know that the vast majority of heroin that's coming into the United States is coming from Mexico, and this really compels us to not only work domestically with demand reduction strategies and with domestic supply reduction strategies, but with our colleagues in Mexico.

I was just in Mexico 2 months ago meeting with our colleagues there, and one of the main agenda items of our security dialogue was what additional actions that the Mexican government can take in terms of eradication of poppy fields, of going after heroin labs. We are seeing a dramatic increase in fentanyl-associated deaths, which we know that the fentanyl, which is this very powerful morphine-like drug that seems to be driving up deaths across the United States, but much of the fentanyl appears to be coming from Mexico as well.

So part of our overall strategy has to be looking at working with our Mexican colleagues, reducing the supply that's coming from Mexico, and working at our border to intercept more heroin that's coming in.

Mr. GROTHMAN. You're telling me something new here, too. I was under the impression a lot of these poppies were growing in Afghanistan or worked over there. You're saying the whole thing is a Mexican thing, growing, produced, da-da-da-da-da, right up here, so it's a Mexican problem and probably another reason why we should be doing a lot better job than we currently are of locking down that southern border.

Mr. BOTTICELLI. Correct.

Mr. GROTHMAN. Okay. On the—how much prison time do you expect to get if you are—first of all, is it a Federal crime, possession of heroin? Is that a Federal crime or just a State crime?

Mr. BOTTICELLI. I believe it's a Federal crime.

Mr. GROTHMAN. You sure?

Mr. BOTTICELLI. I'm pretty sure. I could—yes.

Mr. GROTHMAN. Okay. It's a Federal——

Mr. BOTTICELLI. I am looking at my legal counsel who's telling me this.

Mr. GROTHMAN. If I am caught with enough heroin, which you know I am selling, which is kind of a small amount, but if I am caught with an amount of that, what type of prison sentence can I expect in a Federal court?

Mr. BOTTICELLI. I don't know the exact answer to that in terms of what you can expect, but what we do promote, Congressman, is that we know that many people who sell small amounts of a drug, largely to feed their own addiction, right, so these are not the folks who are preying on our community. But—so we want to make sure that those folks who are doing that activity, largely because of their own addiction, are getting good care and treatment. But, however, we want to make sure——

Mr. GROTHMAN. It's a little shocking that you don't know. I mean, to me, in Wisconsin, you know, we have money for treatment and da-da-da, but a frustrating thing is the cost of heroin is so low, and the reason the cost of heroin is so low is the people who are selling the heroin are not paying enough of a price, okay. I mean,

heroin was around, like, in the 1970s, but it wasn't so abused like it is today. Things are getting a lot worse.

And I think one of reasons why the cost is going down is I am learning today, that I don't think you guys consider enforcement enough of a priority, and enforcement should be a priority. I mean, people are killing people. I believe right now, in the State of Wisconsin, more people are dying of heroin overdose than murder and automobile accidents combined. I think that's certainly true in individual counties. And something the Federal Government can do is to begin to make the cost of heroin go up a little bit.

And I'm a little bit concerned, you know, that you guys are not, Oh, we can't, you know, prosecute our way out of this. Well, you got to try to prosecute your way out of it or the cost of heroin is not going to go up.

Mr. BOTTICELLI. So I will tell you, Congressman, that honestly, when we look at public health strategies to reduce other issues, decreasing the availability and increasing price has been a prime strategy, and that's part of our goal with heroin. Because of the cheap availability of heroin, that we know that that has prompted the dramatic increase, part of the dramatic increase in heroin.

That's part of why we are focusing on domestically working on law enforcement to dismantle these organizations. That's why we continue to work with Mexico on reducing the supply, how we work with Customs and Border Protection to interdict more drugs that are coming in, because we know that there is this nexus between the supply of heroin in many communities and demand.

You know, I will be the first to admit that while we need to continue to ramp up our demand reduction strategies, that needs to complement our demand reduction—or our supply reduction work. I would absolutely agree that we have to really look at how do we diminish the—both the supply of heroin and the trafficking organizations who are moving it.

Mr. GROTHMAN. Right. Good. I hope you do that sincerely, because I'm a little bit afraid to this point, you know, you're just throwing up your hands and saying all we're going to do is education or something or other.

Mr. MEADOWS. Okay. The gentleman's time is expired.

Mr. GROTHMAN. Well, a little shorter than the last one, but that's okay.

Mr. MEADOWS. The chair will recognize the gentleman from Missouri, Mr. Clay, for 5 minutes.

Mr. CLAY. Thank you, Mr. Chairman, and thank you—thank the witnesses for being here. Let me ask of Director Botticelli. You know, and let's stay on the subject of heroin addiction. We are in an epidemic that's afflicting Americans from every part of this country of every background, so reauthorization of your office is timely and urgent.

I've heard you speak eloquently and powerfully about how treatment is one of the ways that we can reduce the 17,000 deaths annually from prescription painkillers, and 8,000 deaths annually from heroin. And I have seen firsthand the value of life-saving and life-renewing services offered by community-based nonprofits that provide residential treatment for substance use disorder.

They provide the full continuum of care for addiction, from residential treatment to outpatient to aftercare support upon completion of their program that is essential to them staying clean and being a productive member of society. So it shouldn't be all about throw them in jail and lock them all up. I think this is a disease that needs to be treated.

And I agree with Mr. Turner. Unfortunately, if you are poor, and you rely on Medicaid for your health care, which we know a lot of States have not expanded, under the ACA, there is an outmoded policy, over 50 years old, known as the Institution of Mental Diseases Exclusion, better known as the IMD exclusion, which bars Medicaid from paying for residential treatment at a facility of more than 16 beds. And The New York Times covered this extensively last year about how the IMD exclusion prevents people from accessing the intensive care they need as heroin addiction is surging.

This yields a two-tiered healthcare system, where only people on Medicaid lose access to a kind of treatment that may be clinically indicated and medically necessary. I believe this is wrong, and it must be changed, and I want to join with my friend from Ohio, Mr. Turner, in trying to change that.

Mr. Director, do you agree that people on Medicaid should have access to the same kind of treatment for substance use disorder of people who don't rely on Medicaid?

Mr. BOTTICELLI. Congressman, thank you for that. You know, one of the things that we know to be effective with dealing with substance use disorders is that people need to be connected to a continuum of care, and that residential rehabilitation, removing people from their environment, giving them new skills, getting them jobs, are particularly important for people's long-term success. So we want to make sure that people have access to the—that everybody has access to that continuum of care, not just people who can afford it out of their own pocket.

I would agree with you that the administration has taken a look at the institute—IMD exclusion, and actually, Secretary Burwell just sent out a letter a number of months ago to State Medicaid directors basically saying that there are a number of levers that Medicaid can use to help support a continuum of care, but to also waiver from the current IMD exclusions.

I know, as I've traveled around the country, I use to administer State-funded treatment programs that many of our programs are under significant demand right now, and that IMD exclusion can seriously limit the ability of our treatment programs to serve more people. So we should want to look at how do we expand treatment capacity, how can we ensure, particularly folks who are on Medicaid, have access to that care.

The last thing that I'll mention is even in spite of the Affordable Care Act and Medicaid expansion in many States, that there are many people who remain uninsured, and I want to make sure that they have access to all of that care as well. So part of our goal at ONDCP in working with Congress is to ensure that our safety net funding, primarily through our Substance Abuse and Prevention and Treatment Block Grant, which every State gets, remains intact so that everybody has access to that full continuum of care.

Mr. CLAY. Yeah. And I'm glad to hear about the plan to approve waivers, but what happens in those States that don't seek waivers? Shouldn't this be a national policy?

Mr. BOTTICELLI. So we actually—through not only the Affordable Care Act, but through the implementation of the Mental Health Equity and Addiction Parity Act, I think really have to look at making sure that we treat addictions like we do any other chronic disease, and that we reimburse for those services like we do with any other chronic disease.

So I think we need to use every tool in our toolbox, whether that's parity enforcement, the block grant, IMD, to make sure that people have access to care when they need it, not just because they can afford it. I'm sure you know, Congressman, that people who realize they need care often have to wait weeks before they get into care and often get very limited duration when they need long-term care and rehabilitation.

Mr. CLAY. Thank you for your response. My time is up. I'm sorry, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman. The chair recognizes the gentleman from Georgia for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman, and thank all of you for being here. Gentlemen, as you can imagine, prescription drug abuse is very important to me. As a pharmacist and the only pharmacist in Congress, I have dealt with this, I've experienced it, I've lived it, I've seen it to—I've seen it ruining lives, I've seen it ruin families, and it's obviously very, very important to me.

As a matter of fact, as a member of the Georgia State Senate, I sponsored Senate Bill 36, which created the prescription drug—monitoring program in the State of Georgia, something I'm very proud of.

And Mr. Botticelli, I wanted to ask you, can you tell me what the National Drug Control Policy, what's your direct role in combating prescription drug abuse?

Mr. BOTTICELLI. So we play a prime role. We know to your—first of all, sir, let me express my appreciation for you and your leadership on this issue, and particularly your focus on prescription drug monitoring programs, because that's been one of our prime goals is to ensure that every State has a robust prescription drug monitoring program.

I'm happy to report that that was one of our main goals when we released our plan. When we started, we only had 20 States that had prescription drug monitoring programs, and to date, we have 49. Part of our role is to make sure that those programs are, to the largest extent possible, adequately resourced. We know that having good real-time data availability, that sharing information becomes important.

Mr. CARTER. Let me—I don't mean to interrupt you, but let me ask you about that. How do you fund those? Through grants or——

Mr. BOTTICELLI. Sir, those are through grants through the Bureau of Justice system.

Mr. CARTER. And in those grants—because I remember when we set up our program, we weren't eligible for certain grants because we did not have certain programs within the prescription drug monitoring program that we needed, for instance, sharing informa-

tion across State lines. I just couldn't get the bill passed at that time with that included in it, which it made us noneligible for those type of grants.

Mr. BOTTICELLI. To my knowledge, I don't know, but I'd be happy to work with you, Congressman, if there are additional eligibility requirements, that you feel like our—become a burden in terms of States not being able to have access to the—to those bills——

Mr. CARTER. Right.

Mr. BOTTICELLI. —I'd be happy to work with you.

Mr. CARTER. Right. Well, certainly, you know, that's an important element, and my hope is that we can get that changed in the State to where we can share information, because that's important.

For instance, I practiced right on the Georgia/South Carolina line and the Georgia/Florida line, so I'd get prescriptions quite often—or I used to practice. I get prescriptions quite often from those States and need that information as well.

I want to switch real quickly. Mr. Maurer, you mentioned a while ago, and I took some interest in this, because I know that in the legalization of marijuana, and the decriminalization of marijuana, I suspect that that's had an impact, and I was wondering if you've done any studies. I've always viewed marijuana, and full disclosure, I am adamantly opposed to the decriminalization, or to the legalization of marijuana.

I am a practicing pharmacist for over 33 years. I have spent my career using medication to improve people's health, and so it is just a pet peeve of mine. But nevertheless, what I want to know is, in those States that have legalized, that have or decriminalized it, had—I've always viewed it as being a gateway drug. Has—have we seen a decrease or an increase or any impact at all in other drug use in those particular States?

Mr. MAURER. We currently have a report that's going through final processing right now looking at part of that issue. It will be issued at the end of this month. It's looking at the experiences in Washington and the State of Colorado, and more specifically, what the Department of Justice is doing or not doing in those States involving their use of marijuana. That report may address some of your questions.

In terms of preparing for today's hearing, we don't—I don't have any specific information in response to your question, but it's right on point, and I think it's an important issue that needs to be addressed. We need to get that information and help inform the policy debate.

Mr. CARTER. Right. Another point that was brought up during this conversation I have found very interesting. We've done quite a bit of criminal justice reform in the State of Georgia, and we've talked about it here in Congress, and certainly having programs in our prison system, because our prisons are full of people who are in there for drug abuse problems and drug—illegal drug use, and we need to have programs in our prison system that are going to treat them because it is a disease. I can tell you, as a professional, it is a disease, and it's something that needs treatment.

What are we doing to help in the prison system, to help with those type of programs?

Mr. MAURER. In the Federal system, which is what I'm familiar with, inmates are eligible for residential drug treatment programs, if they are—if they have come into prison with an addiction, and they can get that treatment and they can get reductions in their sentences if they successfully complete the program.

Mr. CARTER. But—so it's voluntary?

Mr. MAURER. Yes.

Mr. CARTER. It's not required. Why aren't they required?

Mr. MAURER. Why aren't they required?

Mr. CARTER. Yeah. Why aren't they required—if you go into prison for drug abuse or drug dependency, why aren't you required to go through therapy?

Mr. MAURER. I think that's a great question to ask the Bureau of Prisons. In the legislation, the ability to have inmates to have their sentences reduced creates a pretty strong incentive for them, and I know that for a number of years, BOP, Bureau of Prisons didn't have adequate resources to meet the demand for that program. They've since made a lot of progress in addressing that particular issue.

So I can't speak to whether every single inmate who goes into the Federal system actually gets treatment. I do know that many inmates want to get that treatment program, both to address their addiction as well as to get out sooner.

Mr. CARTER. Well, many inmates may want to get that treatment program, but I suspect that all citizens want them to get it. I can assure of you that.

Thank you, Mr. Chairman. I yield back.

Mr. MEADOWS. I thank the gentleman. The chair recognizes the gentleman from Massachusetts, Mr. Lynch, for 5 minutes.

Mr. LYNCH. Thank you, Mr. Chairman, and I want to thank the witnesses for your excellent testimony.

Full disclosure. Mike Botticelli is a pal of mine and used to run the Substance Abuse Bureau in Massachusetts, and Mr. Kelley, my district is a high-intensity drug trafficking area, and Mr. Kelley has been a frequent flier to my district in trying to address the problem there.

Most pointedly, we've had a critical situation in Massachusetts in my district, as well as other parts of the State, and maybe—maybe just explaining that will offer some value to what the office of National Drug Control Policy actually does.

We have had a pernicious problem with heroin coming into my district from Mexico, and it was through Director Botticelli's help that we sort of figured—figured all this out, but it's coming out of Mexico and Colombia. The earlier drug trafficking network was through the Dominican Republican. We had a lot of Dominican gangs that were providing that, as Mr. Kelley had informed us. But between the office of the National Drug Control Policy and HIDTA, we were able to bring in resources from—now, remember, we are dealing with a system that is—we've got local towns, cities, counties, the State, now the—one of the hot areas was Providence, Rhode Island, so we're dealing with Rhode Island as well, and then, of course, we're dealing with the Mexican border and the Mexican Government.

So ONDCP actually pulls all that together so we can get all these resources. They brought—I had a number of homicides in my district that were, that have the population in full alarm, brutal, brutal murders, and directly tied to the drug trade. And so ONDCP did a remarkable job. And I just—you know, from member to member and how you deal with this in your district, ONDCP is a very, very important part of that. And that's—that's how we bring all these resources together, which are scarce.

I do want to express support for Mr. Turner's idea about maybe accessing SAMHSA, but they're short-funded on that end as well, as Director Botticelli pointed out, but maybe we could do something on a pilot program where county prisons or State prisons might identify a certain program in a certain area like Dayton, Ohio or like Gloucester, Massachusetts where we're trying some innovative stuff here to deal with the inmate—or potential inmate population.

So I just appreciate the work that you all have been doing, and thank you, Mr. Maurer, for your testimony as well.

I want to just back up a little bit because one of the—one of the problems that I see on a day-to-day basis, and I'm dealing with it. I'm up to my neck in this stuff in my district, is the power of oxycodone, and I've got—I could tell you some horror stories about, you know, young people that we've been dealing with that, you know, one young woman and had a tooth extraction and got a prescription of OxyContin, and then she falsely—she tells me now she falsely claimed a persistent tooth pain, got another prescription of OxyContin. Two scrips later, she's fully, fully addicted, and then she started complaining about other teeth, having other extractions. So this young woman was having teeth pulled out of her head just to get the OxyContin.

Now, when people are doing that, it tells you that this is a very powerful, powerful drug, and because of the tolerance that—what it does to the brain and because of the tolerance that develops and resistance that develops, greater dosages are needed. So using that as just one example, and I can give you a bunch more, why is it that we're allowing drug companies to produce these powerful, powerful drugs that—by which they are building a customer base for life. By getting people on this OxyContin, it is—it's overloading their brains, and it's just—it's grabbing them, and there's a commercial advantage to producing customers for life.

If you can get these people hooked, you've got them forever, they can't get off this. So, you know—and now the FDA, God bless them, but they just expanded the use to children, and so it seems like we're not—we're not all rowing in the same direction here. I actually—when I was first dealing with it, I actually filed a bill to ban OxyContin, and there were more lawyers and lobbyists all over me on that. I didn't have a prayer.

So how—what is it that we could do to sort of look again at the substance that we're allowing people to sell out there. And I'm not against pain management, but this is ridiculous. We're overmedicated. You know, we've got—you know, it's just off the charts in terms of the opioids that we're putting out in the street. How do we address that issue?

Mr. MEADOWS. If you could briefly respond, sure.

Mr. BOTTICELLI. Thank you, Congressman. So to your point, we are prescribing enough prescription pain medication in the United States to give every adult American their own bottle of pain pills. We all want a balanced approach here, making sure people have access to these lifesaving medications for those who need it.

You know, we continue to work with the FDA to promote abuse deterrent formulations, but one of the areas where we haven't made enough progress, and we'd love to work with Congress on this, is ensuring that every prescriber has a minimal amount of education around safe and opiate—safe and effective opiate prescribing. That's why we're really thrilled with the New England HIDTA in promoting—because that is often the place where it starts, right.

So I'm sure this dentist was—thought he was very well intended in treating someone's pain. I would assume that they got little to no training on pain prescribing, on identifying addictive behavior. So we've got to work on all fronts, not only on making sure that we make these medications more abuse deterrent, but also that we're stopping this overprescribing that we see throughout the country. It's really critical for us to rein in the prescriptions of this, and that critical point, Congressman, is often with a doctor/patient relationship.

Mr. LYNCH. I thank the chairman's indulgence. Thank you. Appreciate it.

Mr. MEADOWS. I thank the gentleman. The chair recognizes himself for a series of questions.

Let me be real brief in terms of the introduction. I think we have a bipartisan agreement that this is something that we need to address. The question for me becomes is with the reauthorization, and some of the suggestions that have been made in that is that the appropriate place and money funding.

I can tell you that I started a nonprofit with a very good friend of mine who lost his grandson, and there is a cycle within that family of drug abuse. And so we went in and developed a nonprofit to work on the prevention side of things. And so this is something that's near and dear to my heart, but I want to—I want to go a little bit closer because I think this is all about coordination.

Mr. Maurer talked about it early on, that there is virtually little, if no coordination, among some of the agencies, and yet we spend billions of dollars. Mr. Kelley, you were talking increasing the authorization amount. I'm willing to really look at that to make sure that you have the resources necessary, but as we look at these caps, I want to make sure that we're not taking away from HIDTA, which I consider more of a law enforcement component, and spending the money on prevention and treatment when it would be better allocated in a different agency that already does prevention and treatment, okay.

And I think you're following where I'm going with this is because it gets back to the mission creep. So let me ask my tougher question to you, first, Director, and that is, is in the reauthorization language, there is talk about getting rid of the new performance reporting system. Why?

Mr. BOTTICELLI. So one of the things that we've looked at, as we've undertaken our reorganization, is how do we achieve greater

efficiency within our organization to really focus on our main goals and our main mission here. And one of the things that we've looked at—and we are fully cognizant of our role, both to ourselves as an agency, to Congress, and to the American people, that we monitor performance, that we are—that——

Mr. MEADOWS. But you came up with this new development performance system. Why get rid of it? Just cut to the chase. How do we—why are you getting rid of it?

Mr. BOTTICELLI. So part of what we're trying to do is achieve greater efficiency within our organization.

Mr. MEADOWS. So how do you do that by getting rid of an evaluation program?

Mr. BOTTICELLI. Because what we've looked at is through the existing—we do have existing mechanisms within our current administration that monitors performance.

Mr. MEADOWS. So who made the mistake of doing the new performance——

Mr. BOTTICELLI. I think——

Mr. MEADOWS. Because you created a new one, and then you're doing away with it, and I don't understand why we would do that.

Mr. BOTTICELLI. So I want to be clear and up front that there were elements of the performance review summary that helped in our ability to continue to monitor performance.

Mr. MEADOWS. All right. Let me be clear and up front. I want you to work with GAO to keep the system of performance review in place. Make it meaningful, make it measured, because the appearance—and I just got finished saying that I'm willing to look at increasing the authorization and renewing it, but the appearance is, is that you didn't meet your performance standard, and you got rid of the program, and that's not satisfactory.

And so, do I have your commitment today to work with Mr. Maurer and the folks at GAO to make that meaningful and put that back in?

Mr. BOTTICELLI. I will be happy to work with you because I do want to assure you——

Mr. MEADOWS. With GAO.

Mr. BOTTICELLI. And with GAO.

Mr. MEADOWS. Okay.

Mr. BOTTICELLI. That we satisfy your request to make sure that we are monitoring and that we are——

Mr. MEADOWS. Performance is all about it, and if we are spending billions of dollars, and we are not getting what we need, then we need to reallocate those funds, okay?

So if you could put up the chart, and this gets back to how I opened up a little bit. This actually—I believe this chart is one that comes from the performance fiscal year 2014 or 2016, excuse me, budget and performance summary that was produced by your group, ONDCP.

So we can see there that prevention and treatment across agencies is substantially higher already. You know, I guess that's $11 billion is where that would be. And so some of the wonderful programs that have been talked about today that actually I've taken advantage of and used with grants and some of those are actually

working in treatment and prevention, and you drop down to the next group, that's domestic law enforcement.

So let me—let me be specific, knowing that you have a willing participant here to help you with the reauthorization. I am very concerned that we're taking HIDTA, and we're making them a treatment and prevention group when we're already spending $11 billion in other agencies to do that, when just better coordination, as Mr. Maurer with GAO has already mentioned, would actually address that.

So what I'd like us to do is relook at that, if we can, and look at—and if we're not meeting the 5 percent cap, you know, and the gentlewoman from the District of Columbia and the gentleman from Maryland had both talked about how that treatment component with HIDTA is effective, but yet we're still not meeting the 5 percent cap that's in pro, what I want to do is make sure that we're allocating the money with the proper agency to perform those functions, and not making a law enforcement officer do treatment and prevention, because I want to give him the tools to refer, but they are not in the treatment and prevention business, they are in the law enforcement business. And when you do that, it is very concerning. Will you agree with that?

Mr. BOTTICELLI. I would agree. You know, one of the things that I do want to point to is that despite the fact that we have significant funding and increased funding for prevention and treatment, we know we have gaps in many parts of the country.

Mr. MEADOWS. I will agree with that, but is HIDTA the best place to do that? Because I can tell you, my bias is that it's not. You can sell me. I'm waiting to hear.

Mr. BOTTICELLI. No. So one of the things we do work with the HIDTA program on is making sure that if they are investing dollars in prevention and treatment, that they go toward evidence-based programs, right.

Mr. MEADOWS. I understand that, but let me tell you, I've got a HIDTA program in three counties, and that is McDowell, Buncombe, and Henderson County in my district, and the only common thread there is transportation. You know, we're looking at main corridors coming from the south. I mean, and—and to do away with money from the HIDTA program there is not addressing the treatment or prevention aspect, because it is all about transportation, and that goes from a—both a Democrat and Republican sheriff that are working in those counties. They work better together, and to reduce their funds concerns me. So you follow my logic?

Mr. BOTTICELLI. So I appreciate your comments on this, and let me just reiterate that, you know, our purpose here with the language was, in no way, shape, or form, to dilute the main mission of our HIDTA program.

Mr. MEADOWS. I believe that.

Mr. BOTTICELLI. Okay.

Mr. MEADOWS. But what I'm saying is, is it could do that if we go that way. So will you readdress the reauthorizing language with that in mind and my bias, and I'll give you, after this time, because I need to go on to my other colleagues.

Mr. BOTTICELLI. Sure.

Mr. MEADOWS. You can try to sell me.

Mr. BOTTICELLI. I think we can, and I think one of the things that we can work on is maybe establishing better criteria for—as we look at the——

Mr. MEADOWS. So let me put it bluntly. Will my sheriffs agree that we need to increase the amount of money going to treatment and prevention in HIDTA and go away from them? Would they agree with that?

Mr. BOTTICELLI. I honestly don't know what the locals are saying.

Mr. MEADOWS. Okay.

Mr. BOTTICELLI. As long—but I will say that they probably would object, and we would object if that dilutes from their main mission.

Mr. MEADOWS. If they object, we're going to have an issue, and I'll go to this——

Mr. BOTTICELLI. And probably on the HIDTA board.

Mr. MEADOWS. Yeah. I'll go to the gentlewoman from the Virgin Islands, Ms. Plaskett, for 5 minutes.

Ms. PLASKETT. Thank you very much, and good morning, gentlemen. Thank you for the work that you do. You know, I am so incredibly appreciative of everything that you all are putting forward in your testimony, your thoughtfulness. My first job out of law school was a narcotics prosecutor in the Bronx, so I understand this completely and the importance of the work that you do.

As a Member of Congress representing the United States Virgin Islands, I very much strongly support the bipartisan effort of reauthorizing the Office of National Drug Control Policy. I see how important it is, not only for our Nation in terms of treatment, but preventative as well in terms of stopping the flow of drugs in and out of this country and its transportation throughout.

For years, the otherwise peaceful communities in the U.S. Virgin Islands have been experiencing elevated levels of crime and violence. Much of it is related to our economy, and that economy has, in turn, moved tremendously to a growth in illegal drug trade. And we are very grateful for HIDTA's presence in the Virgin Islands, and would be in favor of increased presence in the Virgin Islands in Puerto Rico, because we are aware that much of the traffic of drugs that's coming into the mainland is coming through the Caribbean corridor, which many people are not aware of how much drugs are coming into this country through such a small area of the United States.

And so you can imagine, if it's coming through such a small and porous border in this small community, the effect, the tremendous effect it's having on the people that live there, neighborhoods, individuals completely afraid to go out not only at night, but now even during the day where we're having drug wars and shootings occurring, not even blocks away from schools in the middle of the day in this community.

And although a significant effort has been made in recent years to secure additional Federal attention and resources to address drug trafficking through the U.S. territories in the Caribbean, in our opinion, much remains to be done to help stem the flow of drugs and related crime, as well as to diminish the negative impact of drug abuse in the communities across the United States, Virgin Islands, and Puerto Rico.

Now, in response to a congressional directive earlier this year, ONDCP took a major step forward in helping to promote a well-coordinated Federal response to those issues by publishing the first ever Caribbean border counternarcotic strategy. And I would ask you, Director Botticelli, as well as Mr. Kelley, as to whether or not you believe that explicitly including the U.S. Virgin Islands and Puerto Rico and statutory mission of ONDCP would help ensure that drug-related issues facing the American's Caribbean border are fully included in aspects of your work.

Because we're so small in numbers, in population, people are unaware that almost 40 percent of the drugs that come into this country come through those two areas.

Mr. BOTTICELLI. Thank you, Congresswoman, for your question and for your concern. We share your concern in terms of look at trafficking and increasing crime in Puerto Rico and the U.S. Virgin Islands. To do that, we have seen an increased flow in the Caribbean as it relates to some of the drug flows, so we share your concern, and we're happy to comply—to produce the 2015 Caribbean counternarcotic strategy, which addresses a wide range of issues.

We are actually going to be convening all of the relevant stakeholders in early 2016 to review our progress against our goals and ambitions for this, and have every intent, going forward, to include specific action items in our strategy, going forward, that address the Caribbean and U.S. Virgin Islands. It will continue to be a priority.

Ms. PLASKETT. I will work as closely and be as supportive of you as possible in that. You know, our families and our elders, our children really need your support at this time.

Mr. BOTTICELLI. Thank you.

Ms. PLASKETT. Mr. Kelley, do you have any thoughts? I visited HIDTA's—the group in Puerto Rico about a month ago, was impressed by the work that they're doing, have been speaking with even our Coast Guard, who is doing quite a bit of that work as well, and would like to get your thoughts on this.

Mr. KELLEY. Thank you, Congresswoman. In fact, you've struck a number of points that I've written down that are very germane. The HIDTA program has been intimately involved with the Caribbean, not only through our HIDTA program that's there presently, but we, on a monthly basis, we have a conference call, sometimes attended as many as 90 people on the conference call, and it's the Caribbean intelligence conference call where members of not only ONDCP, but all the Federal agencies here in the United States to talk about the transportation of drugs and the sharing of intelligence, and we've made some great, great progress. So much so that it has been a repetitive—a repetitive conference call and will continue to do that.

To your point on including in the reauthorization and the type of border strategy, I think it's very, very important, as we look at the drug issues here in this country, that we not only have to look inward, but we have to insulate ourselves from the outside, and whether it's a northern border strategy or southwest border strategy, or Caribbean border strategy, that is the transportation corridors where these drugs are invading our community.

So it makes perfect sense to me, and I think to ONDCP, or with the strategy that just came out, that the Caribbean is a very, very important partner in this issue of reducing the supply that comes from elsewhere in the world, and we know that we have to take greater strides in protecting not only the people of the Caribbean and those nations and those territories, but to prevent the transportation of drugs through there to make that a no-go zone for these drug trafficking organizations.

Ms. PLASKETT. Thank you very much, gentlemen. Thank you, Mr. Chair. I'm going to be so impressed with working with you all in that, but know that, you know, I'll be on you. I'll be watching.

Mr. KELLEY. Thank you.

Mr. MEADOWS. I thank the gentlewoman, and before I recognize the gentlewoman from New York, Mr. Director, could you—why are you requesting 22 percent less for the HIDTA program?

Mr. BOTTICELLI. So the—part of the challenge——

Mr. MEADOWS. You were just talking about what a good job they do, so you punish them by reducing their budget by 22 percent?

Mr. BOTTICELLI. Again, you know, it's not reflective of what our value of the HIDTA program is. I think you know in the current——

Mr. MEADOWS. My wife was a waitress. She said appreciation is green.

Mr. BOTTICELLI. I know.

Mr. MEADOWS. So what's it reflective of?

Mr. BOTTICELLI. I think it's just a reflection of some challenging priorities that the President's budget has.

Mr. MEADOWS. So where did the other money go? Can you get that to the committee?

Mr. BOTTICELLI. I could get that to the committee.

Mr. MEADOWS. Because I'm concerned.

Mr. BOTTICELLI. Sure.

Mr. MEADOWS. And I'll recognize the gentlewoman from New York, Mrs. Maloney, for 5 minutes, and a gracious 5 minutes.

Mrs. MALONEY. Okay. Thank you very much and thank you for this hearing, all of your testimony, and I join this chairman in really underscoring that you should not be eliminating review processes, but strengthening them, and certainly, knowing the problem that we haven't, we shouldn't be reducing what we're spending, but we should be maintaining it, hopefully growing on it.

But I want to go back to the conversations we've been having on opiates, that they've been prescribed very deeply and strongly and the increase of prescriptions for it. Are you tracking whether the prescriptions are coming from doctors or are there illegal prescriptions?

Mr. BOTTICELLI. As we look at data, the vast majority of prescription pain medications that are coming into the supply are coming from legitimate prescriptions. So we only see a small percentage that are coming from pharmacy—Internet sales or street level purchases. Seventy percent of people who start misusing prescription pain medication get them free from friends and family, who often got those from just one doctor.

But we know as people progress, they often do move from doctor to doctor, but that really comprises a very little proportion of over-

all prescription pain medication in the supply. So we know if we're going to deal with this issue that we've got to diminish the prescription pain medication.

Mrs. MALONEY. And also there are reports that people on opiates then become addicted to heroin. Have you been tracking that? Apparently heroin is cheaper than the opiates. Is that in your database, one of the questions you ask, were you on an opiate before you went to heroin? And then often heroin goes to crime. So——

Mr. BOTTICELLI. So we know that about 80 percent of people, newer users to heroin, started misusing prescription pain medication, because they're both opiates and they act the same way in the brain. We do know, however, that when you look at heroin use, it's much, much lower as a percentage of use than prescription drug misuse.

So we know that it appears that only a small percentage of people are progressing from prescription drug misuse to heroin. However, because of the magnitude of the prescription drug issue, that has led to a really significant increase in the number of people who are using heroin.

Mrs. MALONEY. Well, is there any punishment to doctors that abuse these opiates? I thought the example from Congressman Lynch was astonishing, that the woman had teeth pulled out of her head to get pain medicine. Obviously the doctor was incompetent if he was pulling out of her head teeth that did not deserve to be extracted. And so what is the punishment for a doctor for prescribing pain killers or any medicine inappropriately?

Mr. BOTTICELLI. So I think we have to distinguish between those physicians and dentists who are prescribing who are well intended, who are not doing it with a malice of intent, versus dealing with those physicians who are just doing this as a huge cash business. And we've seen that in many parts of the country.

Mrs. MALONEY. How is it a huge cash business? They just get money for prescribing the drug?

Mr. BOTTICELLI. So let me give you a very telling example. In one county in Florida, because of lax laws and because they didn't have a prescription drug monitoring program, 50 of the top 100 prescribers were in one county in Florida. And working with the DEA, working with the police, working with the prescription drug monitoring program, we were able to enact laws and reduce these huge pill mills that we saw that were often a for-cash business. So law enforcement and reducing those pill mills become a prime strategy for us.

But we've also been working with the Federation of State Medical Boards, who have oversight and disciplinary action as it relates to physicians who are clearly outside of the range of appropriate prescribing, because, you know, taking disciplinary action against those physicians and other prescribers who are clearly outside the bounds of what normal prescribing behavior would be needs to be part of our overall strategy.

Mrs. MALONEY. And my time is almost up, but I did want to ask you, I guess Mr. Maurer, about the GAO released report on ONDCP's coordination efforts of drug abuse prevention. The report identified an overlap in 59 of the 76 programs included in the

GAO's review. And what is the possible impact of this overlap and why did you raise that in your report?

Mr. MAURER. Sure. This was a report we issued back in 2013. At that time, we found overlap. And what we meant by that was that there were disparate programs that could potentially be providing grant funding to the same grant recipient and they wouldn't necessarily know, so the right hand wouldn't necessarily know what the left hand was doing.

The good news on that is we issued our findings, we made recommendations to ONDCP to take a look across this universe of programs. They have done that, they've identified the need for greater coordination, they put mechanisms in place to improve that coordination, they've addressed that recommendation, and we have since closed it as implemented.

Mrs. MALONEY. That's a very fine success.

My time has expired. Thank you.

Mr. MAURER. Thank you.

Mr. MEADOWS. I thank the gentlewoman.

Just so you will know, we are going to do a very, very limited second round, and by very limited, we're going to—I'm going to recognize the gentleman from Wisconsin for 4 minutes, a strict 4 minutes, and then we're going to recognize Ms. Norton for a strict 4 minutes, and then do closing remarks.

The gentleman from Wisconsin is recognized for 4 minutes.

Mr. GROTHMAN. Okay. So I had to come back, because I kind of thought it was a rhetorical question as to whether possession of heroin was a Federal crime. But what is the expected prison term you get if you have enough heroin with you that you're probably some sort of dealer? Do you know what you guys ask for?

Maybe I'll ask Mr. Maurer. What is the standard as you prosecute it locally? What do the Federal prosecutors ask for?

Mr. MAURER. I don't know what the standard sentence is. I do know that there are a lot of factors that go into sentencing. Mandatory minimums would weigh large in this particular case, depending on the amount of heroin.

Mr. GROTHMAN. Is there a mandatory minimum if I have enough heroin that I apparently am not using it for personal use?

Mr. MAURER. It's a function of prosecutorial discretion and what actions they chose to take, but there are mandatory minimums associated with heroin. I don't know what those are, though.

Mr. GROTHMAN. Okay. Do you know how many people are in Federal prison for selling heroin?

Mr. MAURER. I don't know how many are in Federal prison. I do know that well over half of the current Federal inmate population is serving a sentence that's predominantly based on drug possession or drug trafficking.

Mr. GROTHMAN. Okay, the reason I say is to me there's a big difference between heroin and other drugs, okay. I mean, nobody—I'm for marijuana being illegal, but there's nobody, you know, dying of a marijuana overdose. This heroin thing is a whole new thing, you know, much worse than the cocaine thing, much worse than anything, and that's why I don't like it kind of blended with the other things.

But do you know how many prosecutions for heroin, heroin either possession or selling it every year?

Mr. MAURER. I do not know.

Mr. GROTHMAN. Okay. I want you to get me those things.

Mr. GROTHMAN. And I think it's important for you three, who are after all supposed to be the Federal people out in front fighting the heroin, to familiarize yourself a little bit about what's going on in the criminal Federal courts dealing with heroin. I mean, I'm asking you these questions. I thought you'd give me answers, and you don't know the answers.

Mr. MAURER. We'd be happy to work with our colleagues in the executive branch——

Mr. GROTHMAN. You should know the answers. You've got important jobs. And I'm glad you're going to get the answers, but I think if you had your job, I'd know the answers.

But, okay, I guess we'll ask you some more questions later when you have to time get the answer. I'll give you one more question, though, which is an entirely unrelated thing, but kind of a follow-up.

One of the problems we have is that there are physicians out there who are clearly selling prescriptions for opiates that they shouldn't be selling. Another problem, to me, is we have physicians prescribing more opiates than you would traditionally need. You know, somebody goes in for a root canal and instead of giving you a prescription for 3 days, they give you a prescription for a month.

Do you want to comment on that and why that practice has taken hold?

Mr. BOTTICELLI. Sure. We would completely agree with you that not only are we overprescribing, but in many instances people who need only a limited duration of pain medication are getting up to 30- and 60-day doses of that.

Part of what we've been focusing on, not only in terms of our prescriber training, but the Health and Human Services is in the process now of developing clear and consistent clinical guidelines as it relates to the prescribing of pain medication for these exact purposes of not only appropriate prescribing, but also not overprescribing the amount of medications that are given out in many instances.

Mr. GROTHMAN. I'd only just say it's a Federal business, but since so many of the prescriptions today I suppose are paid for Medicare or Medicaid, do you think it would be Federal guidelines on the appropriate amount of opiate prescriptions paid for in these two programs?

Mr. BOTTICELLI. You know, one of the issues that we're particularly looking at with our Medicaid programs is not only the implementation of these clinical standards to looking at, but also continuing to focus on what we call lock-in programs, to ensure that people who might be going to multiple physicians or multiple pharmacies are locked into one physician and one pharmacy.

So we're looking at a wide variety of mechanisms, both within our Medicare and Medicaid programs, to look at how we might diminish the scope and the associated costs with prescription drug use in both of those programs.

Mr. MEADOWS. Thank you. The gentleman's time has expired.

The gentlewoman from the District of Columbia is recognized for 4 minutes.

Ms. NORTON. I certainly appreciate the chairman's indulgence.

I really felt I had to ask you a question on synthetic drugs. And I want to say the chairman mentioned that his sheriffs wouldn't want you to take away from law enforcement function. I would agree with you. My police chief wouldn't want it either, especially in light of the fact that I think you took down 19,000-plus packets of synthetic drugs only recently here in the District of Columbia, and I think it was your very HIDTA law enforcement that did it. It made big news here.

These synthetic drugs present a new challenge. I want to know how you're handling it. We've had in October alone emergency services were called 580 times, more than 18 times a day, to respond to synthetic drug emergencies. Here we have bipartisan legislation that has been introduced. I'm not sure any of it can be found to be constitutional, because unlike heroin, which is what it is, for example, they change the composition.

Are you pursuing synthetic drugs? In light of the fact that a criminal statute cannot be overly broad or it violates due process, do you have the tools to do your law enforcement work with what is now a growing menace across the United States? My Republican members who have this problem, for example, on the bills, come from Texas and Pennsylvania.

Mr. Botticelli.

Mr. BOTTICELLI. Thank you, Congresswoman. I'm glad I have the opportunity to talk about synthetics. And while we've been talking about the opiate addiction, you know, one of our prime concerns has been the dramatic increase in these new psychoactive substances. Both in terms of my job and as a resident of the District, I've seen the incredible impact that it's had.

You know, we have working with our counterparts in China, because we know that the vast majority of these precursor chemicals are coming in from China. We're happy to say that China just moved to schedule over 100 of these substances.

One of the areas, to your point, about how do we stay ahead of these new chemical compositions has been a challenge for us at both the Federal and State level. We're happy to work with Congress in terms of the legislation that's been introduced that would give Federal Government additional and quicker scheduling authority——

Ms. NORTON. You do need, as China is doing new legislation, you do need new legislation to be able to do effective law enforcement?

Mr. BOTTICELLI. I believe that we have not been able to stay ahead of these new chemical compositions and we need to look at——

Ms. NORTON. I have one more question before my time is up. I know that four States and the District of Columbia have legalized possession of small amounts of marijuana. The other four, of course, have legalized sale as well. In D.C., they are sending our people to the illegal market, because you can't get—do the sale.

How much of your work goes for marijuana in light of the fact that this drug is increasingly—you have 20 States that have decriminalized it. Are you really spending resources on marijuana,

particularly in light of the fact that in terms of the white, black, again, getting into what happened with mandatory minimums, the arrest records are almost entirely black or Latino, because the white kids are not in, I suppose, the law enforcement areas and don't get picked up. In light of that racial disparity, how much of your funds for law enforcement goes for marijuana, which is being legalized before your very eyes?

Mr. BOTTICELLI. So I could get you an exact breakdown in terms of where our law enforcement efforts, but I——

Ms. NORTON. Can you send the chairman of this committee a breakdown in terms of——

Mr. BOTTICELLI. Sure.

Ms. NORTON. Mr. Kelley has a breakdown.

Mr. KELLEY. No. I was going to address one other issue that you raised, if I may, if the chairman allows.

Ms. NORTON. Well, excuse me. Could this question be answered, Mr. Botticelli?

Mr. BOTTICELLI. I'd be happy to do that. But I think to your point, you know, the vast majority of the resources that ONDCP and the Federal Government looks at are really for enhanced prevention and treatment programs. You know, we don't—and I think the Federal Government and the Department of Justice has issued guidance saying that we are not going to be using our limited Federal resources to focus on low-level folks who are using this for largely personal use. I think you've heard today that folks want to use every opportunity to divert people away from the criminal justice system.

But I do have concerns based on the data that we shared here in terms of marijuana use what the implications of both decriminalization and legalization mean for the people of the United States. I've been doing public health work for a long time. We know there are disproportionate health impacts, particularly with poor folks——

Ms. NORTON. Well, I support those studies, especially when it comes to children. Of course, we know that most people don't smoke marijuana once they leave college.

Mr. MEADOWS. Mr. Kelley, we'll give you some latitude to make that last comment, then we'll close up.

Mr. KELLEY. Thank you, Mr. Chairman.

Congresswoman, I just wanted to bring your attention—for the record, I would certainly in the Washington-Baltimore HIDTA, which is in your district, I would certainly invite you—in fact, I spoke to the Director prior to coming down here, knowing that this is a prevalent issue here—I would invite you, that he would be able to speak to you at any time that you wish.

I also have with me a threat assessment that was done on synthetics in this very area and a number of recommendations, which I'll be glad to share with you.

Mr. KELLEY. That was developed by the Washington-Baltimore HIDTA in their initiatives that they're working very closely with the chief of police, who sits on their board, to address these very issues.

Mr. MEADOWS. Thank you, Mr. Kelley.

And I'd just like to thank all of you for your testimony, for your indulgence. It's been a very insightful hearing.

I want to—Director, we have a number of to-do items for you to get back.

It is critical, because as we look for reauthorization, as we get back into a normal budgeting process, a normal appropriations process, some of these have been appropriated without reauthorizing, as you know. Those days are growing fewer in number, and so it is more critical that we look at reauthorization, but look at meaningful budget numbers too.

I am extremely troubled, based on the testimony today, that your request is to cut a program. Now, if it's not working, cut it all out, but that's not what I heard from you. And then yet we're taking a program that what my local law enforcement officers say works with them, it's a critical tool, and we're somehow wanting to give greater flexibility—it appears that we're wanting to shift the money into prevention and treatment and ultimately do away with HIDTA. And you're going to meet great resistance in a bipartisan way here, I think, if that's truly the direction. And I don't want to put words in your mouth. You're very eloquent with your words.

So I just want to say thank you all for your time. I think we can make real good progress here working through. Director, you have to do, to work with GAO to make sure that we keep those performance reviews in a meaningful and statistically accurate manner.

And if there is no further business, without objection, the subcommittee stands adjourned.

[Whereupon, at 12:16 p.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

RESPONSES TO
QUESTIONS SUBMITTED FOR THE RECORD TO
MICHAEL P. BOTTICELLI
DIRECTOR
OFFICE OF NATIONAL DRUG CONTROL POLICY

FOLLOWING DECEMBER 2, 2015, HEARING ENTITLED,
"OFFICE OF NATIONAL DRUG CONTROL POLICY: REAUTHORIZATION"
SUBCOMMITTEE ON GOVERNMENT OPERATIONS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

The Honorable Mark Meadows

1. Please provide a summary of the types of drug prevention activities HIDTAs have funded.

ANSWER: The High Intensity Drug Trafficking Areas (HIDTA) program collaborates with community-based organizations and community coalitions to fund prevention activities and programs throughout the 28 HIDTA regions. HIDTA funds prevention initiatives with two underlying aims based on principals articulated in the *National Drug Control Strategy* (*Strategy*): the first is to prevent drug use before it begins; and the second is to promote positive change in communities by increasing public awareness of the dangers of drug use. HIDTA prevention initiatives accomplish these goals by building community coalitions and partnerships that bring together law enforcement, educational, social service, and community-based organizations to provide community prevention programs. These programs are conducted in schools, community coalitions, civic organizations and faith-based organizations. Information sharing sessions, symposiums, public forums, and prevention conferences are held for law enforcement professionals and their coalition partners to improve prevention strategies within their respective communities. Also funded are targeted, local media campaigns that advertise on television, the Internet, radio, newspapers, cinemas, buses, bus shelters, and strategically placed billboards on travel corridors to promote anti-drug messaging. Below is a description of some of the prevention initiatives funded by HIDTAs.

Appalachia HIDTA
No More NAS (Neonatal Abstinence Syndrome) Prevention Initiative. Partnership between Appalachia HIDTA, the Knoxville Police Department, and the Metropolitan Drug Commission to network with the Born Drug Free Tennessee campaign, Cherokee Health Systems and the University of Tennessee to screen women of childbearing age for their risk of substance use by using evidence-based screening tools. Among pregnant women in Knox County, Tennessee, who are being treated for substance use disorders through TennCare, 41 percent listed prescription opioids as their primary substance of use. . The Tennessee Department of Health began a NAS registry in 2013 and 921 drug-exposed infants were reported. The screenings offer an opportunity for women in Knoxville to be counseled to reduce risk and/or access treatment to reduce NAS in babies born to pregnant women who either use substances non-medically or those who are taking prescribed opioids but are unaware of their risks.

Atlanta/Carolinas HIDTA
The Asheville initiative is a joint effort between the McDowell County, North Carolina Sheriff's Office and the McDowell County Health Coalition ("Coalition"). Perception of risk strongly coincides with youth decision making as to whether to experiment with drug use. Therefore, the goal of this initiative is to reduce substance use in the county through youth prevention education activities. Funding supports training of School Resource Officers and Coalition members in evidence-based prevention education. In-class presentations are conducted throughout the McDowell County School System with additional presentations taking place at community organizations where parents are present. Pre-and post-test evaluations are conducted to determine if participants' perception of the risk of drug use has changed, gauging whether an increase in knowledge of the dangers and risks of drug use has occurred. Information about community-based substance use disorder treatment programs is provided during community presentations.

Houston HIDTA
StopHoustonDrugs. An interactive web portal hosted by Houston HIDTA. The StopHoustonDrugs is a website that improves communication between law enforcement, treatment and prevention professionals providing them a platform to post trends, questions and promote better communication between the professions. The website creates similar platforms of this web address for surrounding areas such as Corpus Christi, Victoria and Beaumont. Houston advertises on billboards and public transportation – cabs and buses – that is on the list of effective research-based prevention programs.

Houston HIDTA Drug Prevention and Awareness Initiative. Partnered with the Houston Mayor's office Crackdown Coalition, this initiative is a concerted and collaborative drug prevention and awareness effort. The coalition consists of law enforcement and treatment/prevention health professionals, working in partnership to increase awareness of drug trafficking, substance use, and community drug use trends, while also working toward breaking the cycle of addiction and incarceration. The coalition seeks to reach grassroots organizations including law enforcement, the faith community, educators, counselors, health care professionals and other involved in community-based prevention efforts.

Midwest HIDTA
St. Louis County Multi-Jurisdictional Task Force (MJDTF) Heroin Prevention Initiative. The initiative increases public awareness, participation in community prevention and collaborative efforts between law enforcement, outreach groups and the health department. The initiative promotes its prevention efforts through town hall style meetings, wellness meetings and conventions on prevention and treatment of people with substance use disorders. The initiative focuses on prevention through public awareness using traditional advertising methods such as radio ads, bus stop ads, movie theater ads, and strategically placed public billboards on travel corridors leading to and from the area.

New England HIDTA
North Shore HIDTA Task Force –Essex County Sheriff's Department (ECSD) Prevention Initiative. Participants of the Youth Leadership Academy are educated on the dangers of drug use and the risk factors leading to youth violence and criminal street gang membership. Classes

and presentations are supported by the Essex County District Attorney's Office and teaches coping skills to participants to resist the temptations of drug use.

New York/New Jersey HIDTA
Saturday Night Lights. The goal of this initiative is to reduce youth violence and youth drug use in neighborhoods plagued by violence and crime by offering free, professional and exceptional athletic training during the most vulnerable hours – often Friday and Saturday nights – to girls and boys ages 12-18 who live or go to school in high risk neighborhoods.

North Florida HIDTA
The Crime Prevention Initiative. North Florida HIDTA partners with the Drug Free Duval, and Clay and Nassau Drug Free Communities through information sharing by attending routine meetings, receiving informational bulletins and conducting telephone and face-to-face interviews with treatment and prevention community professionals. Through these mechanisms, North Florida HIDTA keeps abreast of the full picture of drug supply and demand and use trends in the region.

Southwest Border - West Texas Region
West Texas HIDTA Prevention Initiative. The purpose of this initiative is to better connect local law enforcement with community-based prevention activities to help reduce substance use and create safer and healthier communities. Goals include, enabling law enforcement officers to participate in the design and implementation of science-based community prevention programs in schools, community coalitions, civic organizations and faith based organizations.

Washington/Baltimore HIDTA
Prince William County Prevention. This initiative is designed to reduce drug trafficking and use, gang activity and criminal activity in the Georgetown South neighborhood in Manassas, Virginia. The initiative has accomplished this through local government partnerships with community organizations, schools, Juvenile Court Services Unit and the Manassas City Police Department to promote youth responsibility and family empowerment.

Richmond Neighborhood Drug Intervention and Prevention Initiative. This initiative is designed to eliminate open-air drug markets operating throughout Richmond, Virginia, by combining aggressive enforcement with intervention and prevention strategies. This initiative will mobilize neighborhood residents, businesses and service organizations to work with law enforcement in order to reduce drug use and its consequences in Richmond.

Baltimore's Violence Prevention and Community Engagement Initiative (BVPCEI). The initiative prevents and reduces drug use and violent crime in Baltimore by developing neighborhood-based public safety strategies and programs through a collaborative partnership between the residents of Baltimore, community organizations, the Baltimore Police Department and the Mayor's Office on Criminal Justice (MOCJ). Citizens and police support each other in preventing and reducing drug and gang related crime by enhancing communication between law enforcement and the community and by creating problem-solving relationships and prevention programs appropriate for each community.

Wisconsin HIDTA
Safe & Sound. This initiative is part of the City of Milwaukee's strategy to reduce drug-related violent crime through targeted law enforcement, community building, and proactive engagement of youth in activities that teach resistance to drugs, gangs, guns and crime. The initiative implements an integrated team approach by developing neighborhood programs that involve a Safe & Sound Community Organizer, a Youth Organizer, and a Community Prosecution Unit. These Safe & Sound teams work closely with law enforcement, residents, and prosecutors to address neighborhood problems such as open-air drug markets, drug houses, graffiti and other crimes.

2. Please provide a full accounting of annual prevention spending, past and present, by individual HIDTAs, including each individual HIDTA's annual budget, the individual HIDTA's annual prevention spending, and the individual HIDTA's annual prevention spending as a percentage of its budget for each respective year.

    a. Please also provide a full accounting of annual treatment spending at the Washington-Baltimore HIDTA, including the Washington-Baltimore HIDTA's annual budget, its annual treatment spending, and its annual treatment spending as a percentage of its budget for each respective year.

ANSWER: Please see the attached chart for information on the HIDTA Program's annual budget from FY 2011 to FY 2015. Consistent with our statutory requirements, no more than 5 percent of the Federal funds appropriated for the HIDTA Program have been spent on drug prevention activities.

As this information indicates, the Northwest and Wisconsin HIDTAs have consistently allocated the highest percentages of their budgets for local prevention programs. Descriptions of the Northwest and Wisconsin HIDTAs' prevention activities follow:

Northwest HIDTA's Prevention/Public Education Initiative – This initiative promotes collaboration among community-based prevention coalitions and law enforcement agencies. Coalition members prepare and distribute drug prevention information to the media, parents, teachers, clergy, social services professionals, and community leaders throughout the Northwest HIDTA region. In addition, in response to an increase in opioid deaths in this region, the Northwest HIDTA supports prescription drug take-back activities, public awareness campaigns, and naloxone distribution efforts.

Wisconsin HIDTA's Safe & Sound Initiative – This initiative is part of the City of Milwaukee's strategy to reduce drug-related violent crime through targeted law enforcement, community building, and proactive engagement of youth in activities that teach resistance to drugs, gangs, guns and crime. The initiative implements an integrated team approach by developing neighborhood programs that involve a Safe & Sound Community Organizer, a Youth Organizer, and a Community Prosecution Unit. These Safe & Sound teams work closely with law enforcement, residents, and prosecutors to address neighborhood problems such as open-air drug markets, drug houses, graffiti and other crimes.

Descriptions of the Washington/Baltimore HIDTAs' treatment initiatives follow:

Washington/Baltimore HIDTA's Treatment/Criminal Justice Initiatives – These initiatives support drug courts and/or treatment programs in the cities of Alexandria (VA), Baltimore (MD), and Richmond (VA); in the counties of Anne Arundel (MD), Arlington (VA), Fairfax (VA), and Prince Georges (MD); and in the Virginia Department of Corrections. The initiatives support a range of services—from drug court programs to residential treatment to efforts to transition offenders with substance use disorders back into communities. Overall, the HIDTA strives to forge strategic partnerships between criminal justice/corrections agencies and treatment- and recovery-service providers to ensure that intervention and treatment services are combined with intense supervision and guaranteed sanctions.

3. How would local HIDTA authorities be involved in the prevention and treatment spending under ONDCP's proposed language for a reauthorization bill?

   a. What types of prevention and treatment activities could HIDTAs fund?

   b. How would ONDCP or individual HIDTAs ensure that prevention and treatment activities funded by HIDTAs are not duplicative of other programs?

ANSWER: The Office of National Drug Control Policy's (ONDCP) proposed reauthorization bill adds new language stating that, upon the request of a HIDTA executive board, the ONDCP Director may authorize the expenditure of an amount greater than 5 percent of program funds for drug prevention programs. The new language also authorizes the expenditure of program funds to support initiatives that provide access to treatment for substance use disorders as part of a diversion or alternative sentencing or community reentry program for drug offenders. This change would empower the HIDTA executive board, which is composed of representatives from the geographic region the HIDTA serves and who are authorities on the needs of that region, to allocate HIDTA funds in excess of the current 5 percent cap for prevention and to authorize expansion of treatment programs that are part of alternative sentencing or community reentry programs.

The prevention and treatment activities funded by the HIDTA program are often unique partnerships between public health and public safety and are responsive to the needs and concerns of the communities they serve. ONDCP does not direct the HIDTA programs to develop or support prevention or treatment initiatives, rather the HIDTA executive boards determine whether to request resources for these activities and they also decide what types of initiatives to develop and support. This enables the HIDTAs to engage in activities that directly address their specific drug threats.

The HIDTAs connect law enforcement with community-based prevention efforts as endorsed by the *National Drug Control Strategy*. HIDTAs collaborate with community-based organizations and community coalitions to fund prevention activities and substance use disorder treatment services working toward non-duplication of prevention and treatment activities in the community.

4. What is ONDCP's process for determining individual HIDTA regions' annual budget allocation?

    a. Please provide any corresponding methodology or policies associated with the HIDTA budget allocation process.

    b. How has the HIDTA budget allocation process or methodology changed over time?

ANSWER: Regional HIDTA programs receive annual base funding allocations and supplemental (discretionary) awards.

HIDTA Base Allocation
Each year, all HIDTAs submit threat assessments, strategies, and initiatives with corresponding budget proposals that detail their plans to combat identified threats in their regions. ONDCP conducts a comprehensive review of each HIDTA's proposal to ensure compliance with both programmatic and fiscal guidelines. For the past several years, Congress has included a provision in ONDCP's annual appropriation that restricts the base funding for any HIDTA from being lower than the base level that was provided the previous year. Thus, almost all of the HIDTAs base funding is determined by the previous year's funding levels.

Given that limitation, HIDTA baseline funding nonetheless can be increased to reflect the addition of new counties to a HIDTA, if funds are available. In general, the designation of additional counties within a HIDTA would include additional funding for those areas based on an evaluation of the threat being addressed and the existing resources available in the new HIDTA counties.

Supplemental Funding
HIDTA programs may also receive supplemental (discretionary) awards through a competitive process for the funds that are available after the base allocation and auditing services expenses have been determined. HIDTA programs submit requests to ONDCP that outline the drug-related threats in their region and the proposed strategy to address those threats. Discretionary funding requests should include elements that address one or more of the following strategic categories:

- Strengthen the HIDTA program infrastructure, either regionally or nationally, such as enhanced connectivity and information sharing;
- Address emergent drug threats, such as the production and trafficking of synthetic drugs, heroin, and new threats in areas petitioned for HIDTA designation; and
- Advance *National Drug Control Strategy* priorities, such as prevention activities that enable law enforcement personnel to participate in community prevention efforts.

The requests are reviewed and prioritized by ONDCP staff, in coordination with the HIDTA Directors Committee.

The HIDTA budget allocation process and the methodology have not changed in recent years.

5. Will HIDTAs that choose to engage in prevention and treatment spending receive priority or favoritism in the budget allocation process?

   a. Would prioritizing or favoring HIDTAs that expend funds for prevention and treatment efforts create a false incentive for engaging in those efforts, rather than doing so based solely on the need of that particular HIDTA?
   b. How does ONDCP plan to mitigate this potential incentive?

ANSWER: ONDCP does not currently, and will not under the proposed reauthorization, direct the HIDTA programs to develop or support prevention or treatment initiatives. Rather, the HIDTA executive boards determine whether to support these activities, and they also decide what types of initiatives to develop and support. This enables the HIDTAs to engage in activities that directly address their specific drug threats. All HIDTAs receive funding based on the need to carry out the initiatives to address the drug trafficking threat in their respective regions of the country.

6. How does ONDCP create the National Drug Control Strategy and corresponding goals, and how are stakeholders involved in this process?

ANSWER: Section 706(a)(3)(A) of the ONDCP Reauthorization Act of 1998, as amended, specifies the process for development and submission of the *Strategy*. This section states:

> [T]he Director shall consult with—
> (i) the heads of the National Drug Control Program agencies;
> (ii) Congress;
> (iii) State, local, and tribal officials;
> (iv) private citizens and organizations, including community and faith-based organizations with experience and expertise in demand reduction;
> (v) private citizens and organizations with experience and expertise in supply reduction; and
> (vi) appropriate representatives of foreign governments

In 2009, at the beginning of the Obama Administration, then-Director Kerlikowske traveled throughout the country to consult with state, local and tribal government officials, law enforcement, non-governmental organizations, and citizens on the direction the Obama Administration's drug policy should take. This process led directly to the development and production of the Administration's first *Strategy*.

With the understanding gleaned from this consultation process, ONDCP established two goals at the outset of the Administration: one that focused on reducing the consumption of illicit drugs, and one that focused on reducing the public health and public safety consequences of the use of these illicit drugs. Progress toward achieving the first goal was assessed with four measures of the consumption of illicit drugs among various populations, including youth, young adults, and

chronic users. The second goal was supported by three measures of drug-related morbidity and mortality and drugged driving. These two goals and seven measures underwent an interagency consensus review process and have remained consistent over the course of the Administration.

In accordance with the agency's authorization, each year ONDCP begins the *Strategy* development process by sending out letters to the heads of drug control agencies; Members of Congress; state, local, and tribal officials; private citizens and organizations with experience and expertise in demand and supply reduction; and appropriate representatives of foreign governments seeking their consultation on the development of the *Strategy*. Responses received to these consultation letters are then reviewed by ONDCP staff who prepare the various chapters of the *Strategy*. The resulting *Strategy* draft is then submitted for an interagency review process overseen by the Office of Management and Budget.

7. How does ONDCP revise the National Drug Control Strategy and corresponding goals to address evolving drug control efforts and substance use trends?

ANSWER: As stated in Section 706(a)(1) of ONDCP's 1998 Reauthorization Act, as amended, ONDCP, acting for the President, is required each year to:

> submit to Congress a National Drug Control Strategy, which shall set forth a comprehensive plan for the year to reduce illicit drug use and the consequences of such illicit drug use in the United States by limiting the availability of, and reducing the demand for, illegal drugs.

The production of the annual *Strategy* is an iterative process. While the two goals (see response to Question 6 above) have remained the same throughout the course of the Administration—reduce illicit drug use and reduce the consequences of such use—the policies and programs implemented to achieve them are continually assessed and updated as necessary. The *Strategy's* goals and measures are supported by more than 120 Action Items, i.e., specific activities and programs undertaken by Federal drug control agencies that, if successful, will assist the Nation in achieving the *Strategy's* goals. Each year the progress toward achieving the Action Items is assessed through an interagency process. If ONDCP and its Federal partners determine progress is lagging, ONDCP issues guidance to the relevant agencies through the annual budget development process (described in response to Question 8 below), to increase the effort to achieve the Action Item.

Additionally, as issues emerge, ONDCP has revised the *Strategy* to address those issues. For example, the Nation has experienced an alarming increase in the consequences of the non-medical use of opioid medications. One of the more troubling consequences of this use is neonatal abstinence syndrome, in which mothers using opioids (whether legally or illegally) while pregnant give birth to infants who have been exposed to opioids. In last year's *Strategy*, ONDCP and its Federal partners established four new Action Items specific to addressing neonatal abstinence syndrome.

8. What steps does ONDCP take to ensure that federal agencies' drug control budgets in the National Drug Control Budget correspond to the goals in the National Drug Control Strategy?

ANSWER: Each year, ONDCP engages in an extensive consultation process to develop the *Strategy* and the drug control budget. The process involves meetings and discussions with key stakeholders to determine drug control priorities and meetings with senior Drug Control Program agency officials to help identify the funding priorities necessary to achieve the objectives of the *Strategy*. ONDCP uses this input in crafting its annual funding guidance to National Drug Control Program agencies. These agencies use ONDCP's funding guidance to assist in identifying funding priorities as agencies develop their budget submissions. Most Drug Control Program agencies submit budgets twice during the budget development process. The first submission occurs when the bureau submits a budget to the Department. The second submission occurs when the Department submits it budget to the Office of Management and Budget for review. ONDCP reviews the agency budgets to ensure that budgets align to the *Strategy* and support the budget recommendations outlined by the ONDCP.

9. What authority does ONDCP have to influence federal agencies' drug control spending or to adjust funding priorities or spending at agencies whose budgets do not align with the National Drug Control Strategy?

ANSWER: ONDCP has several mechanisms to ensure that Federal Drug Control Program agencies' funding priorities align to the *Strategy*. The *Strategy* itself outlines drug policy goals and objectives. ONDCP funding guidance, issued to Drug Control Program agencies annually, identifies the specific funding priorities needed to support the implementation of the *Strategy*. During the budget formulation process, ONDCP receives budget submissions from Drug Control Program agencies identifying proposed funding levels. ONDCP reviews the budget submissions and works with agencies to ensure that the funding levels for drug control efforts support ONDCP funding priorities. If ONDCP determines funding levels provided by a Drug Control Program agency are not adequate to ensure the implementation of the objectives of the *Strategy*, ONDCP has the authority to decertify the agency's budget. Finally, ONDCP has the authority to issue a Fund Control Notice to direct the use of funding appropriated to a Drug Control Program agency.

Given ONDCP's early and ongoing engagements with Drug Control Program agencies during the budget development process, ONDCP has not decertified a budget in more than a decade.

10. To what extent does the National Drug Control Budget represent a complete view of federal drug control activities in the United States?

ANSWER: ONDCP designates agencies that are responsible for implementing any aspect of the National Drug Control Strategy as Drug Control Program agencies. ONDCP strives to ensure that the Drug Control Program provides comprehensive reporting of all drug control funding for agencies that meet criteria showing their programs or activities are closely related to drug control

efforts and for which reasonable scoring methodologies to track and report drug control funds can be established. By statute, certain agencies in the intelligence community are not included as part of the Drug Control Program.

11. Does ONDCP have any plans to remove or add agencies from the National Drug Control Budget?

ANSWER: ONDCP reviews Federal programs and activities on an ongoing basis to determine if agencies should be added or removed from the Drug Control Program. For example, in December 2015 ONDCP designated the Centers for Disease Control and Prevention (CDC) as a Drug Control Program agency. CDC will begin reporting drug control funding for CDC Prescription Drug Overdose and CDC Illicit Opioid Use Risk Factors in the FY 2017 Budget Summary. ONDCP will make future updates as warranted, based on its ongoing review process.

12. How does ONDCP ensure that its action items will lead to the full achievement of its goals in the National Drug Control Strategy?

ANSWER: ONDCP and the Federal drug control community make every effort to ensure that the Action Items are fully implemented. In developing the 2010 *Strategy*, the Administration's inaugural *Strategy*, ONDCP worked closely with the Federal drug control community to establish the *Strategy* Goals and Measures, and the Action Items, those programs and activities considered essential to achieving the Goals and Measures. At the same time, ONDCP and its Federal partners established the Performance Reporting System (PRS) to assess annually the progress achieved toward meeting specific quantitative targets consistent with the *Strategy* Goals, Measures and Action Items. As with any set of goals, it is not possible to ensure they will be met. There is a strong aspirational aspect to goal setting, to inspire and motivate stakeholders to achieve them. This is certainly the case with the *Strategy*'s goals and has been the case for ONDCP's strategic goals for every Administration since 1989, when the agency was established. In setting the Goals and Measures for the *Strategy*, ONDCP was deliberately aggressive in setting the 2015 targets, fully cognizant that it was setting a high bar to be achieved.

The *Strategy* is a plan for the Nation as a whole to address drug use and its consequences; it is not limited to the Federal Government's activity. In addition, there are times when unanticipated events or factors beyond the control of the Federal Government intervene to slow progress (or block it altogether) toward implementing specific Action Items and thus prevent the Nation from achieving the Strategy's Goals and Measures.

13. Given that ONDCP has not met its 2015 goals, what are ONDCP's plans for future National Drug Control Strategy goals?

ANSWER: At the commencement of the Administration, ONDCP established the two Strategy Goals of reducing illicit drug use and the consequences of that use and the seven quantitative Measures with target dates of 2015 (or 2014 in the case of the drugged driving Measure) to assist

in assessing progress toward achieving the goals. While 2015 has passed, it is not quite accurate to state that ONDCP has not met its 2015 Goals. Not all of the data used to track whether the Measures (and thus the Goals) have been achieved has become available. In fact, only the data for two of the Measures—lifetime use of alcohol, tobacco, and illicit drugs among 8th graders and the prevalence of weekend nighttime driving after having consumed an illicit drug or medication with the ability to impair driving—is available to state conclusively whether Measures have been achieved. Until all of the data are in it is not possible at this point to conclude whether ONDCP has met its Strategic Goals.

Moreover, the Nation actually has already met some of the Measures and is on track to achieve others by the time the relevant 2015 data become available. For example, Measure 1b deals with reductions in the lifetime prevalence of 8th grade use of illicit drugs, alcohol and tobacco (as measured by cigarette use). The Nation has exceeded the 2015 targets for alcohol and tobacco (26.1% vs 31.1% for alcohol and 13.3% vs. 17.1% for tobacco). The Nation also has exceeded the 2015 target for diagnoses of HIV infections attributed to drug use—the 2015 target was to decrease the number of such cases to 4,929; in 2013, there were 4,366 such cases. The Nation also is on track to achieve two of the components of the chronic users Measure—cocaine and methamphetamine use—by the time the 2015 data become available.

There are no plans to alter the current Strategy Goals or develop new ones during the final year of the current Administration. Given the lag-time involved in any of the data that could be used to track such new or revised Goals, results to assess whether the Goals were met would not be available until well after the end of the Administration. The next Administration and its ONDCP leadership will establish Strategy Goals consistent with its drug control policy priorities.

14. How do ONDCP's current systems help prevent and detect overlap and duplication in drug control efforts?

ANSWER: ONDCP coordinates Federal drug control policy and budget. In order to effectively coordinate these functions, ONDCP has established a series of interagency working groups to coordinate drug control programs in support of policy objectives and a budget review process to ensure that Drug Control Program agency funding requests support the objectives of the *Strategy*. ONDCP uses the interagency working groups and the budget review process to ensure the efficient use of Federal resources. This includes monitoring programs, ensuring greater coordination among programs, and looking for opportunities to consolidate programs to achieve the objectives of the *Strategy*.

15. In 2013, GAO found that drug abuse prevention and treatment programs were fragmented across 15 federal agencies and provide some overlapping services, which could increase the risk of duplication. How did ONDCP respond to GAO's recommendation that ONDCP assess the extent of overlap and duplication across drug abuse prevention and treatment activities?

ANSWER: As a follow up to this GAO report, ONDCP undertook an assessment of the extent

of overlap, duplication, and coordination, and where overlap exists, we evaluated the extent and effectiveness of coordination among the programs.

ONDCP's review started with the General Accountability Office (GAO) list of 76 programs, and added prevention and treatment programs not included, bringing the list to 130 programs. For each of the 130 programs and agency activities considered, ONDCP reviewed the authorizing language, the most recent grant solicitation, and agency performance reporting to determine who the program or agency activity serves (the beneficiaries) and what services were being provided.

ONDCP found that most often programs and agency activities cannot overlap because the eligible beneficiaries and services are unique. The review determined 91 of the 130 programs provide either unique services or serve unique beneficiaries, and accordingly do not overlap with other drug prevention and treatment programs. The remaining 39 programs could potentially overlap to some degree. A review of the 39 programs found that most of these programs are well coordinated through interagency collaboration and coordinated grant applications and agency activities.

ONDCP will continue to monitor both these 39 programs that could potentially overlap, as well as new Federal programs that are added to prevent and treat substance use disorders. This monitoring will include requiring regular reporting from the Departments that oversee these particular programs, as a part of inter-agency prevention and treatment working group meetings.

16. In ONDCP's 2014 assessment, it noted that some programs would benefit from greater coordination. What has ONDCP done to ensure greater coordination among these programs?

ANSWER: Please see response to question 15 above.

17. What steps does ONDCP plan to take to help prevent future duplication in the programs and activities it oversees?

ANSWER: Please see response to question 15 above.

18. In a 2013 GAO report on field-based entities that share intelligence on issues such as criminal and counterterrorism activities, GAO found that ONDCP, along with other federal agencies, could better coordinate to reduce potential overlap. How have ONDCP and the HIDTA program responded to GAO's recommendation regarding coordination?

ANSWER: In response to the GAO report, the HIDTAs, Regional Information Sharing System (RISS) centers and state/major urban fusion centers have been committed to collaboration, de-confliction and improved coordination through joint intelligence production meetings, investigative support operations and major special event support. ONDCP has been supportive of these efforts and has provided encouragement to the HIDTAs to improve the coordination of and collaboration between field-based information sharing entities. To enhance the coordination and reduce potential overlap of criminal and counterterrorism intelligence activities the HIDTA

Directors' Committee selected a chairperson for their intelligence committee to act a as a liaison to the leaders of the other field-based entities. That position has improved the level of collaboration over the past few years and helped draft processes and strategies that are creating a high level of cohesion among those field-based intelligence entities.

Over the past 2 years the HIDTAs in the Northeast, the New England State Police Information Network - RISS center, and the Northeast state and major urban area fusion centers have collaborated in the development of the Drug Monitoring Initiative (DMI) to provide better coordination of narcotics-based threat analysis to the region. The efforts have improved coordination of information collection, analysis, and the dissemination of critical narcotics threat information to law enforcement, public safety first responders, and public health departments. The DMI partnerships have led to the development of a Regional Information Sharing Environment Concept of Operations that is currently being finalized with the support of the Program Manager for the Information Sharing Environment.

Over the past 2 years the HIDTA program also has been coordinating with the Department of Homeland Security (DHS) on the development of a national request for information tool. The tool will be located within the Homeland Security Intelligence Network's Intelligence Community of Interest and will be used to de-conflict and manage requests for information initially between the Terrorist Screening Center and state and major urban area fusion centers, followed by participation from HIDTA investigative support centers (ISCs) and RISS centers.

From January to July 2014, ONDCP, DHS, the Federal Bureau of Investigation (FBI), the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), as well as HIDTA, RISS, and fusion center representatives, along with many of America's major public safety associations developed the National Strategy for the National Network of Fusion Centers. (https://nfcausa.org/html/National%20Strategy%20for%20the%20National%20Network%20of%20Fusion%20Centers.pdf) This strategy incorporates initiatives that include:

- Developing an outreach and engagement strategy for state, tribal, and regional law enforcement and public safety organizations and associations.
- Developing a strategy to address and provide information on fusion center activities, capabilities, and demonstrations of the value of the fusion center to leadership, including how fusion centers collaborate and partner with other field-based information sharing programs, including Joint Terrorism Task Forces (JTTFs), RISS Centers, and HIDTA ISCs.
- Supporting and helping lead national efforts to align information sharing with field-based intelligence and information sharing partners, including RISS, HIDTA, JTTF, and fusion nodes, in a manner that increases the actionable knowledge of public safety partners and improves information sharing efficiency and effectiveness.

In June 2014, ONDCP and the Program Manager for the Information Sharing Environment supported a Drug Enforcement Administration (DEA) and HIDTA-led meeting with fusion centers, RISS, DHS, and the FBI to develop a joint threat analysis project for the National Opioid/Heroin Threat Assessment. The meeting culminated in the development of a repeatable national threat assessment process based on the collaboration of all of the participating field

based information sharing entities. The National Heroin Threat Assessment was released in April 2015. The next national narcotic assessment planned for 2016 will be focused on methamphetamine.

The HIDTAs also have been working closely with the other field-based information sharing entities and the El Paso Intelligence Center (EPIC) to improve information sharing related to transnational organized crime groups, including drug trafficking organizations. The nationwide de-confliction systems' "data broker" is located at EPIC, and the relationship has already produced improved effectiveness and efficiency for all of America's field-based intelligence and information sharing entities.

Last year DHS, through Federal Emergency Management Agency grant guidance, followed a best practice from the HIDTA Program in mandating the participation in the nationwide interconnected de-confliction systems for all fusion centers that provide investigative case support as a requirement for DHS grant eligibility for state and major urban fusion centers.

On July 4, 2015, HIDTA, RISS, FBI, DHS, and state and major urban area fusion centers' representatives participated in the collaborative information sharing environment of HSIN's Situational Awareness (SitAware) Connect tool to assist in the monitoring of threats to the nation. The HSIN SitAware Connect platform is supported by DHS, managed by the fusion center network and supported through the field-based information sharing entities that include the HIDTA ISCs, FBI, DHS Intelligence & Analysis, and RISS centers. This was the first time that representatives of all entities collaborated in a single work space, and more 400 people participated throughout the day.

In October 2015, the HIDTA intelligence committee chairman and the Superintendent of the New Jersey State Police proposed a new methodology of developing criminal intelligence project prioritization on behalf of the Criminal Intelligence Coordinating Council (CICC) to the Director of National Intelligence, the FBI Director, the DHS Deputy Secretary, the DHS Undersecretary of Intelligence & Analysis, the DEA Chief of Intelligence, and the ATF Assistant Director of Intelligence. The proposal received an astoundingly positive response from our Nation's intelligence leaders.

On January 21, 2016, the criminal intelligence prioritization plan was reviewed, lead Federal agencies were identified, and the plan was approved by the CICC with Deputy Attorney General Yates.

On February 7, 2016, the Super Bowl was held in the San Francisco Bay area. The event held a National Security Special Event – Special Event Assessment Rating of One ("NSSE-SEAR 1"), as outlined in Homeland Security Presidential Directive 7, which is the highest rating given—indicating a significant potential for being a target of terrorism. Starting 7 days prior to the game, there were 167 sanctioned events for the celebration of the 50th Anniversary of the playing of the Super Bowl. The event area stretched across a distance of 45 miles from San Francisco to Santa Clara, California.

The intelligence joint task team that coordinated the information/intelligence collection, production and dissemination was composed of the FBI-JTTF/Field Intelligence Groups (FIGs), HIDTA, and the regional fusion center. The team was also supported by the Western States Information Network (WSIN) - RISS center. WSIN triaged calls from the "See Something, Say Something" campaign and other request for information calls for the HIDTA and fusion center. The week-long series of events that culminated into the Super Bowl highlighted years of work between field-based information sharing entities to establish partnerships that can support both the security of major special events and the prevention and response to major threats to national security. The extremely well-coordinated operation between the HIDTA, fusion center, FBI JTTF/FIG and RISS center was the most direct response possible to the GAO's recommendation regarding coordination between field-based entities that share intelligence.

19. GAO also identified overlap in three systems used between HIDTA Investigative Support Centers and Regional Information Sharing System (RISS) centers. RISS and HIDTA officials signed a memorandum of understanding to coordinate on two of the three duplicative systems, and GAO recommended that they coordinate on the third system, SAFETNet. What steps has ONDCP taken to ensure that these systems are not duplicative?

ANSWER: The GAO recommended that ONDCP, in conjunction with HIDTA officials, work to establish timelines to ensure the interoperability of the three field-based event deconfliction systems (CaseExplore, RISSafe, and SAFETNet) currently in use. Event deconfliction is essential in preventing "Blue on Blue" tragedy. In May 2015, officials representing the three systems signed a Memorandum of Understanding authorizing the integration of the systems and ensuring their interoperability, and the three systems have been operationally integrated for the past six months. As of January 2016, more than 1,500 agencies were participating in the 3 systems and, collectively, entered more than 223,000 events. Of these, 1,000 events were "matched," demonstrating the functionality of the systems' interoperability as well as their importance to officer safety.

20. Please provide the total number of heroin-associated deaths in the United States in 2014 and, if available, 2015.

    a. Please also provide these figures broken down by state.

ANSWER: In 2014, there were 10,574 deaths involving heroin; the age-adjusted death rate was 3.4 deaths per 100,000 population. The 2015 mortality data are expected to be released by December 2016.

These data are from the CDC National Center for Health Statistics, Multiple Cause of Death, as extracted by ONDCP from the CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) Online Database on December 9, 2015. The attached tables (A-9 and A-10, respectively) provide: (1) the number of deaths from drug poisoning involving heroin, by state or jurisdiction, 1999-2014; and (2) deaths per 100,000 population from drug poisoning involving heroin, by state or jurisdiction, 1999-2014 (age-adjusted).

The Honorable Tim Walberg

1. To what extent does the *National Southwest Border Counternarcotics Strategy* specifically address increases in heroin trafficking occurring along the United States border with Mexico?

    a. To what extent does the *National Northern Border Counternarcotics Strategy* address heroin trafficking?

ANSWER: The *National Southwest Border Counternarcotics Strategy* includes several Supporting Actions that are intended to enhance efforts to both significantly decrease criminal organization activity and safeguard and protect the lives of American citizens. These Supporting Actions, when well-implemented, will be effective in ameliorating the recent scourge of heroin trafficking and use, while also having an impact on other illegal substances crossing the southwest border.

The *National Northern Border Counternarcotics Strategy* addresses all drug-related threats affecting the U.S.–Canada border region; however, case reporting and border seizures indicate that cross-border heroin trafficking is a limited threat.

The trafficking, distribution, and use of heroin is regarded as an emerging threat in the Bakken oil field region in northeastern Montana, northwestern North Dakota, and southern Saskatchewan, and the *National Northern Border Counternarcotics Strategy* addresses Federal efforts to respond to this threat.

2. Has there been an increase in heroin or fentanyl trafficking across the northern border of the United States?

ANSWER: Mexico is the primary supplier of heroin to the United States, with Mexican drug traffickers producing heroin in Mexico and smuggling the finished product into the United States through a variety of means.[1] From 2013 to 2014, the estimated poppy cultivation in Mexico increased from 11,000 hectares to 17,000 hectares, with estimated potential heroin production increasing from 26 metric tons to 42 metric tons.[2]

The reemergence of fentanyl, a powerful Schedule II synthetic opioid analgesic more potent than morphine or heroin,[3] has compounded the heroin crisis. These drugs are often indistinguishable. Traffickers who add fentanyl as an adulterant to boost the effect of their heroin, or mix it with diluents to create and sell as synthetic heroin, likely utilize the same supply chains and distribution mechanisms for both drugs.

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[1] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.

[2] US Department of State, Bureau of International Narcotics and Law Enforcement Affairs. International Narcotics Control Strategy Report - 2015 [INCSR] (March 2015) for data from 2013 - 2014 and unpublished U.S. Government Estimates.

[3] Zuurmond WW, Meert TF, and Noorduin H. (2002). Partial versus full agonists for opioid-mediated analgesia--focus on fentanyl and buprenorphine. Acta Anaesthesiol Belg, 53(3):193-201.

In addition, both heroin and clandestinely-produced fentanyl can be manufactured by the same drug trafficking organizations using precursor chemicals from the same sources, and those traffickers can bring both drugs into the country using the same trafficking routes. Illicit fentanyl comes from several sources, most often from fentanyl that is clandestinely manufactured using precursor chemicals, often from China, and far less frequently from diversion of pharmaceutical fentanyl from legal medical use.[4]

Currently, the majority of heroin available in the United States is being transported from Mexico, and a small amount of heroin is being seized at the Northern border of the United States.[5] In Fiscal Year 2015, U.S. Customs and Border Protection (CBP) reported that it seized approximately 1.86 kilograms of heroin at or between its points of entry along the Northern land border. The majority of the heroin, 7 incidents, was seized in the Detroit Sector encompassing Michigan, Ohio, Illinois and Indiana. In comparison, in 2015, 546.25 kilograms or 102 incidents were seized at one port of entry, the Otay Mesa Point of Entry in San Diego, California. Twenty-eight percent of all heroin seized at the Southwest border was seized at Otay Mesa. In addition, according to Canadian law enforcement, the heroin available in Canada is predominantly from Southwest Asia and does not appear to be entering the United States through the Northern border.[6]

Although a small amount of heroin and fentanyl is coming to the United States through the Northern border, an exclusive focus on Mexican production and trafficking could create the opportunity for drugs produced in other areas of the world and trafficked by different organizations to be smuggled into the United States. Therefore, one of the responsibilities of the National Heroin Coordination Group (discussed in further detail in Question 3 below) is to work with the interagency in developing robust information-sharing and data collection and analysis capacity to address all heroin and fentanyl trafficking threats to the United States.

3. How does ONDCP work with law enforcement so they are able to identify labs in Mexico that may be trafficking heroin or fentanyl into the country?

ANSWER: With the alarming increase of heroin and illicit fentanyl use and availability and the rising number of overdose deaths, the *2015 National Drug Control Strategy*'s international supply reduction efforts are focusing on disrupting and dismantling criminal trafficking organizations; working with international community to reduce cultivation of poppy; and identifying labs creating synthetic opioids like fentanyl and acetyl-fentanyl.

The Office of National Drug Control Policy (ONDCP) is integral to the development, implementation and fulfillment of the *National Drug Control Strategy's* supply reduction priorities. ONDCP works with the drug control agencies of the Department of Defense, Department of Homeland Security, Department of Justice, Department of State, and the

[4] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.
[5] Ibid.
[6] U.S. Department of Justice, Drug Enforcement Administration, Ottawa Country Office Reporting. December 2013

Department of Treasury to coordinate efforts in support of the Administration's policy objectives.

To enhance synchronization and coordination of the Administration's efforts, in October 2015 ONDCP established the National Heroin Coordination Group (NHCG). The NHCG, a multidisciplinary team of subject matter experts drawn from within and outside of ONDCP, will serve as .the hub of a network of interagency staff who can leverage their home agency authorities and resources with the desired result of significantly reducing the heroin-related deaths in the United States.

The NHCG will work in close coordination with the National Security Council (NSC) to ensure all interagency activities are synchronized and aligned with the NSC's Transnational Organized Crime and Mexico policy priorities.

In early March, the ONDCP Director and the Associate Director for the NHCG traveled with State Department Assistant Secretary William Brownfield to Mexico to engage the Government of Mexico on tangible actions both governments can take to disrupt the manufacture and trafficking of heroin and fentanyl.

Office of National Drug Control Policy: Reauthorization
HIDTA Annual Budget (Includes Baseline and Discretionary Funding)
FY 2011 - FY 2015 ($ in millions)

HIDTA	FY 2011			FY 2012			FY 2013		
	Total	Prevention	Percentage	Total	Prevention	Percentage	Total	Prevention	Percentage
Appalachia	$ 7.3	$ -	0.0%	$ 7.5	$ -	0.0%	$ 7.0	$ 0.03	0.4%
Atlanta/Carolinas *[formerly Atlanta]*	6.8	0.06	0.9%	7.1	0.04	0.5%	6.2	0.02	0.2%
Central Florida	3.2	-	0.0%	3.3	-	0.0%	3.1	-	0.0%
Central Valley California	4.3	-	0.0%	4.1	-	0.0%	3.4	-	0.0%
Chicago	5.6	-	0.0%	5.7	-	0.0%	5.5	-	0.0%
Gulf Coast	8.2	-	0.0%	8.2	-	0.0%	7.7	-	0.0%
Hawaii	3.2	-	0.0%	3.1	-	0.0%	3.0	-	0.0%
Houston	11.0	-	0.0%	10.4	0.02	0.2%	9.9	0.02	0.2%
Lake County	3.2	-	0.0%	3.2	-	0.0%	3.1	-	0.0%
Los Angeles	14.9	-	0.0%	15.0	-	0.0%	14.3	-	0.0%
Michigan	3.6	-	0.0%	3.6	0.03	0.7%	3.3	-	0.0%
Midwest	14.1	-	0.0%	14.1	-	0.0%	13.5	-	0.0%
Nevada	3.3	0.03	0.9%	3.3	-	0.0%	3.0	0.02	0.5%
New England	3.5	0.07	2.0%	3.5	0.07	2.0%	3.2	0.05	1.6%
New York/New Jersey	12.9	-	0.0%	12.9	0.07	0.5%	12.5	-	0.0%
Northern California	3.4	-	0.0%	3.4	-	0.0%	3.2	-	0.0%
Northern Florida	3.2	-	0.0%	3.2	-	0.0%	3.1	0.08	2.4%
Northwest	5.1	0.59	11.6%	5.0	0.58	11.6%	4.4	0.53	12.1%
Ohio	3.7	0.04	1.1%	3.7	0.04	1.1%	3.3	0.03	0.9%
Oregon/Idaho *[formerly Oregon]*	3.6	0.08	2.1%	3.5	0.07	2.0%	3.1	-	0.0%
Philadelphia/Camden	4.4	0.04	0.9%	4.4	-	0.0%	4.3	-	0.0%
Puerto Rico/U.S. Virgin Isl.	9.5	0.06	0.6%	9.6	0.12	1.2%	9.3	0.10	1.1%
Rocky Mountain	9.8	-	0.0%	9.8	-	0.0%	9.4	-	0.0%
South Florida *[includes NHAC]*	15.1	-	0.0%	15.2	-	0.0%	14.8	-	0.0%
Southwest Border	51.1	0.47	0.9%	50.8	0.47	0.9%	48.6	0.34	0.7%
SWB Arizona [non-add]	*12.3*	*0.05*	0.4%	*12.3*	*0.08*	0.6%	*11.9*	-	0.0%
SWB California [non-add]	*12.4*	*0.34*	2.8%	*12.2*	*0.34*	2.8%	*11.5*	*0.29*	2.6%
SWB New Mexico [non-add]	*8.6*	-	0.0%	*8.6*	*0.04*	0.5%	*8.3*	*0.02*	0.2%
SWB South Texas [non-add]	*9.2*	*0.03*	0.3%	*9.1*	-	0.0%	*8.9*	*0.03*	0.3%
SWB West Texas [non-add]	*8.6*	*0.05*	0.6%	*8.5*	*0.02*	0.2%	*8.1*	-	0.0%
Texoma *[formerly North Texas]*	3.1	0.04	1.3%	3.3	0.04	1.2%	3.0	0.03	1.0%
Washington/Baltimore	13.6	0.57	4.2%	13.6	0.57	4.2%	13.4	0.57	4.2%
Wisconsin *[formerly Milwaukee]*	5.3	0.81	15.2%	5.4	0.81	15.0%	5.1	0.76	14.8%
Other	2.5			2.7			2.6		
Total	**$ 238.5**	**$ 2.85**	**1.2%**	**$238.5**	**$ 2.92**	**1.2%**	**$226.0**	**$ 2.56**	**1.1%**
	Total	**Treatment**	**Percentage**	**Total**	**Treatment**	**Percentage**	**Total**	**Treatment**	**Percentage**
Northwest	$ 5.1	0.39	7.7%	$ 5.0	0.39	7.8%	$ 4.4	0.39	8.9%
Washington/Baltimore	13.6	3.74	27.5%	13.6	3.73	27.4%	13.4	3.57	26.6%

Notes: FY 2013 funding reflects government-wide sequestrations, including sequestrations for funding associated with prevention and treatment.
Other includes auditing services and associated activities. Other in FY 2015 includes $1.0 million for unallocated discretionary funding and $2.7 million for auditing services and associated activities.

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	Total	Prevention	Percentage	Total	Prevention	Percentage
Appalachia	$ 7.4	$ -	0.0%	$ 8.2	$ 0.27	3.3%
Atlanta/Carolinas *[formerly Atlanta]*	6.5	-	0.0%	6.5	0.01	0.2%
Central Florida	3.3	0.01	0.3%	3.4	0.01	0.4%
Central Valley California	3.9	-	0.0%	4.1	0.01	0.1%
Chicago	5.8	-	0.0%	5.8	-	0.0%
Gulf Coast	8.1	-	0.0%	8.3	-	0.0%
Hawaii	3.1	-	0.0%	3.2	0.05	1.6%
Houston	10.3	0.06	0.5%	10.3	0.05	0.5%
Lake County	3.3	0.03	0.8%	3.3	0.03	0.9%
Los Angeles	14.8	-	0.0%	15.2	-	0.0%
Michigan	3.5	-	0.0%	3.5	0.03	0.7%
Midwest	14.1	0.15	1.0%	14.3	0.11	0.8%
Nevada	3.2	-	0.0%	3.2	0.03	0.8%
New England	3.6	0.08	2.2%	3.9	0.05	1.3%
New York/New Jersey	13.4	-	0.0%	13.9	0.13	0.9%
Northern California	3.3	-	0.0%	3.4	-	0.0%
Northern Florida	3.2	-	0.0%	3.3	-	0.0%
Northwest	4.7	0.65	13.9%	4.9	0.60	12.3%
Ohio	3.6	0.07	2.0%	3.6	0.07	2.0%
Oregon/Idaho *[formerly Oregon]*	3.5	-	0.0%	3.7	-	0.0%
Philadelphia/Camden	4.4	-	0.0%	5.3	0.26	5.0%
Puerto Rico/U.S. Virgin Isl.	9.6	0.19	2.0%	9.6	0.14	1.5%
Rocky Mountain	9.8	-	0.0%	9.8	0.03	0.3%
South Florida *[includes NHAC]*	16.4	-	0.0%	16.4	0.02	0.1%
Southwest Border	49.7	0.45	0.9%	50.0	0.72	1.4%
SWB Arizona [non-add]	*12.2*	-	0.0%	*12.4*	*0.18*	1.4%
SWB California [non-add]	*11.0*	*0.35*	3.2%	*11.1*	*0.35*	3.1%
SWB New Mexico [non-add]	*8.7*	*0.10*	1.1%	*8.6*	*0.08*	0.9%
SWB South Texas [non-add]	*9.3*	-	0.0%	*9.4*	*0.05*	0.5%
SWB West Texas [non-add]	*8.5*	-	0.0%	*8.6*	*0.07*	0.8%
Texoma *[formerly North Texas]*	3.4	-	0.0%	3.6	-	0.0%
Washington/Baltimore	14.4	0.58	4.1%	14.9	0.58	3.9%
Wisconsin *[formerly Milwaukee]*	5.5	0.86	15.4%	5.6	0.86	15.2%
Other	2.7			3.7		
Total	**$238.5**	**$ 3.11**	**1.3%**	**$245.0**	**$ 4.05**	**1.7%**
	Total	**Treatment**	**Percentage**	**Total**	**Treatment**	**Percentage**
Northwest	$ 4.7	0.39	8.3%	$ 4.9	0.39	7.9%
Washington/Baltimore	14.4	3.68	25.6%	14.9	3.38	22.7%

Notes: FY 2013 funding reflects government-wide sequestrations, including sequestrations for funding associated with prevention and treatment.
Other includes auditing services and associated activities. Other in FY 2015 includes $1.0 million for unallocated discretionary funding and $2.7 million for auditing services and associated activities.

A-9. Number of Deaths from Drug Poisoning Involving Heroin, By State or Jurisdiction, 1999-2014

State or jurisdiction	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Alabama											12		14	35	40	122
Alaska													12	23	24	25
Arizona	23	14	23	24	64	40	32	52	51	63	84	90	117	101	146	197
Arkansas																
California	468	330	220	361	351	286	251	274	291	325	352	326	364	362	486	561
Colorado	42	38	23	28	21	23	41	39	39	48	70	46	79	91	120	156
Connecticut	96	110	95	88	109	92	74	87	118	109	99	77	85	98	227	299
Delaware	14			14					10			16	15	20	39	54
District of Columbia[1]	19											16	23	25	35	37
Florida	124	170	202	206	205	140	108	87	78	108	96	52	62	101	181	344
Georgia[1]									11	23	21	10	30	40	67	153
Hawaii															10	12
Idaho																11
Illinois	30	35	37	48	20	36	49	63	63	107	116	150	168	269	584	711
Indiana							15		19	56	63	56	68	114	160	173
Iowa										10			14	14	31	37
Kansas											11			16	12	19
Kentucky										12	23	37	55	143	215	228
Louisiana								14		14	11	14	17	51	121	107
Maine														12	16	38
Maryland				28	29	75	79	111	129	105	156	94	103	173	217	313
Massachusetts	17		18	17	23	14	20	37	68	58	61	68	144	246	288	469
Michigan	39	87	81	65	70	94	151	149	114	216	250	215	267	263	421	525
Minnesota											16	16	44	46	92	100
Mississippi															10	23
Missouri	48	48	24	53	42	57	52	61	67	120	162	183	250	210	261	334
Montana																

See notes at end of table.

Table A-9 (Cont'd). Number of Deaths from Drug Poisoning Involving Heroin, By State or Jurisdiction, 1999-2014

State or jurisdiction	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska																
Nevada	43	39	24	39	36	27	46	36	42	31	22	19	40	45	48	64
New Hampshire										11	24	13	42	39	67	98
New Jersey[1]	207	206	196	239	214	118	168	106	103	116	19	97	131	304	383	424
New Mexico	23	40	22	23	25	33	45	21	28	65	48	21	68	104	89	139
New York	41	27	57	50	49	33	35	111	196	219	251	193	334	516	666	825
North Carolina	43	41	50	47	52	49	62	57	50	64	76	39	82	152	189	266
North Dakota																
Ohio[1]	53	77	86	118	91	129	134	124	156	238	214	355	438	696	998	1,208
Oklahoma		12									17		14	26	22	26
Oregon	65	31	37	42	34	47	39	60	110	93	117	81	133	130	103	124
Pennsylvania	182	145	120	138	165	131	138	94	86	158	175	131	240	324	409	503
Rhode Island								10					12	30	65	66
South Carolina		11								11	19	15	12	19	32	64
South Dakota																
Tennessee	11						12				21	17	19	50	69	148
Texas	107	111	179	178	188	201	203	212	214	250	305	261	368	367	369	425
Utah	55	46	39	26	31	22	44	46	51	68	54	55	73	84	122	110
Vermont														10	20	33
Virginia	65	64	89	89	90	68	61	71	95	87	104	45	103	121	206	253
Washington	57	56	46	70	63	57	54	54	75	67	67	60	148	177	206	289
West Virginia[1]									21	36	19	28	34	63	144	163
Wisconsin	16	29	24	27	26	22	31	29	34	67	75	92	135	185	232	270
Wyoming																10
United States	*1,963*	*1,843*	*1,784*	*2,092*	*2,084*	*1,879*	*2,010*	*2,089*	*2,402*	*3,041*	*3,279*	*3,038*	*4,397*	*5,927*	*8,260*	*10,574*

Data are suppressed due to confidentiality constraints.

Note: Drug poisoning deaths include the following ICD-10 underlying cause codes: X40-X44, X60-X64, X85, Y10-Y-14. Drug poisoning deaths include unintentional (accidental overdose), intentional (suicide or homicide by drug), and deaths of undetermined intention. Heroin-involved drug poisoning deaths include ICD-10 multiple cause codes T40.0 (opium) and T40.1 (heroin).

[1]In 2009, there were fewer than expected deaths identified with drug poisoning causes due to an unusually high number of deaths for which cause of death was pending investigation and not updated at the time NCHS closed its files. These deaths are coded under *Other ill-defined and unspecifice cause* (ICD-10 code R99), which has resulted in fewer numbers of drug-induced deaths in the District of Columbia, New Jersey, Ohio, and West Virginia than would have been the case if additional information from the investigations had been incorporated in the file. Data for 2005 in West Virginia and 2008 in Georgia were similarly affected. Trend data for these locations must be used with caution.

Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, *Multiple Cause of Death* on CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 9, 2015.

A-10. Deaths Per 100,000 Population from Drug Poisoning Involving Heroin, By State or Jurisdiction, 1999-2014 (Age-Adjusted)

State or jurisdiction	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Alabama														0.8	0.8	2.7
Alaska														2.9	3.2	3.3
Arizona	0.5		0.5	0.5	1.2	0.8	0.6	0.9	0.9	1.1	1.4	1.5	1.9	1.6	2.3	3.1
Arkansas																
California	1.4	1.0	0.7	1.0	1.0	0.8	0.7	0.8	0.8	0.9	0.9	0.8	0.9	0.9	1.2	1.4
Colorado	0.9	0.8	0.5	0.6	0.4	0.5	0.8	0.8	0.8	0.9	1.4	0.9	1.5	1.8	2.3	2.9
Connecticut	2.8	3.2	2.8	2.6	3.2	2.8	2.2	2.5	3.5	3.2	2.9	2.3	2.5	2.9	6.5	8.9
Delaware														2.4	4.5	6.3
District of Columbia[1]													3.6	4.4	5.1	5.5
Florida	0.8	1.1	1.3	1.3	1.3	0.9	0.7	0.5	0.5	0.6	0.5	0.3	0.4	0.6	1.0	1.9
Georgia[1]										0.2	0.2		0.3	0.4	0.7	1.6
Hawaii																
Idaho																
Illinois	0.2	0.3	0.3	0.4	0.2	0.3	0.4	0.5	0.5	0.8	0.9	1.2	1.3	2.1	4.6	5.6
Indiana										0.9	1.0	0.9	1.1	1.8	2.6	2.8
Iowa															1.0	1.3
Kansas																
Kentucky											0.6	0.9	1.3	3.4	5.1	5.5
Louisiana														1.1	2.7	2.4
Maine																3.1
Maryland				0.5	0.5	1.3	1.4	1.9	2.3	1.8	2.7	1.6	1.8	2.9	3.6	5.2
Massachusetts					0.4		0.3	0.6	1.1	0.9	0.9	1.1	2.2	3.8	4.4	7.2
Michigan	0.4	0.9	0.8	0.6	0.7	0.9	1.5	1.5	1.1	2.2	2.6	2.2	2.8	2.8	4.5	5.5
Minnesota													0.8	0.9	1.7	1.9
Mississippi																0.8
Missouri	0.9	0.9	0.4	1.0	0.7	1.0	0.9	1.1	1.1	2.1	2.8	3.2	4.4	3.7	4.6	5.8
Montana																

See notes at end of table.

Table A-10 (Cont'd). Deaths Per 100,000 Population from Drug Poisoning Involving Heroin, By State or Jurisdiction, 1999-2014 (Age-Adjusted)

State or Jurisdiction	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska																
Nevada	2.2	1.9	1.1	1.8	1.6	1.2	1.9	1.4	1.6	1.2	0.8		1.5	1.6	1.7	2.2
New Hampshire											2.0		3.4	3.5	5.5	8.1
New Jersey[1]	2.4	2.4	2.3	2.7	2.5	1.4	2.0	1.2	1.2	1.3		1.1	1.5	3.6	4.4	4.8
New Mexico	1.2	2.2	1.2	1.3	1.4	1.8	2.5	1.1	1.4	3.3	2.4	1.1	3.4	5.2	4.6	7.2
New York	0.2	0.1	0.3	0.3	0.3	0.2	0.2	0.6	1.0	1.1	1.3	1.0	1.7	2.6	3.3	4.2
North Carolina	0.5	0.5	0.6	0.5	0.6	0.6	0.7	0.6	0.6	0.7	0.8	0.4	0.9	1.6	2.0	2.8
North Dakota																
Ohio[1]	0.5	0.7	0.8	1.0	0.8	1.1	1.2	1.1	1.4	2.1	2.0	3.3	4.0	6.4	9.1	11.1
Oklahoma														0.7	0.6	0.7
Oregon	1.9	0.9	1.1	1.2	1.0	1.3	1.1	1.6	3.0	2.5	3.1	2.0	3.5	3.5	2.7	3.2
Pennsylvania	1.5	1.2	1.0	1.2	1.4	1.1	1.1	0.8	0.7	1.3	1.4	1.1	2.0	2.7	3.4	4.3
Rhode Island														2.9	6.5	6.8
South Carolina															0.7	1.4
South Dakota																
Tennessee											0.4			0.8	1.1	2.3
Texas	0.5	0.5	0.8	0.8	0.9	0.9	0.9	0.9	0.9	1.0	1.2	1.0	1.4	1.4	1.4	1.6
Utah	2.8	2.3	1.9	1.2	1.3	0.9	1.9	1.8	1.9	2.7	2.1	1.9	2.7	3.0	4.2	3.8
Vermont															3.5	5.8
Virginia	0.9	0.9	1.2	1.2	1.2	0.9	0.8	0.9	1.2	1.1	1.3	0.5	1.3	1.4	2.5	3.1
Washington	0.9	0.9	0.8	1.1	1.0	0.9	0.8	0.8	1.2	1.0	1.0	0.9	2.2	2.5	2.9	4.1
West Virginia[1]									1.2	2.1		1.7	2.0	3.8	8.7	9.8
Wisconsin		0.5	0.4	0.5	0.5	0.4	0.6	0.6	0.6	1.2	1.4	1.7	2.5	3.4	4.3	4.9
Wyoming																
United States	*0.7*	*0.7*	*0.6*	*0.7*	*0.7*	*0.6*	*0.7*	*0.7*	*0.8*	*1*	*1.1*	*1.0*	*1.4*	*1.9*	*2.7*	*3.4*

Data are suppressed due to confidentiality constraints.

Note: Drug poisoning deaths include the following ICD-10 underlying cause codes: X40-X44, X60-X64, X85, Y10-Y-14. Drug poisoning deaths include unintentional (accidental overdose), intentional (suicide or homicide by drug), and deaths of undetermined intention. Heroin-involved drug poisoning deaths include ICD-10 multiple cause codes T40.0 (opium) and T40.1 (heroin).

[1]In 2009, there were fewer than expected deaths identified with drug poisoning causes due to an unusually high number of deaths for which cause of death was pending investigation and not updated at the time NCHS closed its files. These deaths are coded under *Other ill-defined and unspecific cause* (ICD-10 code R99), which has resulted in fewer numbers of drug-induced deaths in the District of Columbia, New Jersey, Ohio, and West Virginia than would have been the case if additional information from the investigations had been incorporated in the file. Data for 2005 in West Virginia and 2008 in Georgia were similarly affected. Trend data for these locations must be used with caution.

NA – not available. Due to the small number of deaths involved, death rate estimates were deemed unreliable.

Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Multiple Cause of Death on CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) Online Database, released 2015, extracted on December 9, 2015.