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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.

[Prepared statement of Mr. Meadows follows:]

******** COMMITTEE INSERT ********

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 noted 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 amounts 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.

[Prepared statement of Mr. Connolly follows:]

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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.

[Prepared statement of Mr. Cummings follows:]

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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.

[The information follows:]

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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 Association. 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.

STATEMENTS OF THE HONORABLE MICHAEL BOTTICELLI, DIRECTOR OF NATIONAL DRUG CONTROL POLICY, OFFICE OF NATIONAL DRUG CONTROL POLICY; MR. DAVID KELLEY, CONGRESSIONAL LIAISON, NATIONAL HIDTA DIRECTORS ASSOCIATION; AND MR. DAVID MAURER, DIRECTOR, JUSTICE AND LAW ENFORCEMENT ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

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 treatment 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:]

******** INSERT 1-1 ********

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:]

******** INSERT 1-2 ********

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:]

******** INSERT 1-3 ********

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 Congressman 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, and I quote, "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 lifesaving 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, quote, "mixed," end quote, 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 to 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?

RPTR KERR

EDTR ROSEN

[11:00 a.m.]

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 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 personally 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 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 30s, 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 average 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 enforcement, 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 indicate, 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 or 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 used 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 information 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 off 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? Will 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?

RPTR HUMISTON

EDTR CRYSTAL

[11:58 p.m.]

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 overall 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.

[The information follows:]

******** COMMITTEE INSERT ********

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.

[The information follows:]

******** COMMITTEE INSERT ********

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.

[The information follows:]

******** COMMITTEE INSERT ********

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.]