



Department of Justice

STATEMENT OF

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BEFORE THE

**COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES**

FOR A HEARING ON

THE HEROIN USE AND OPIOID ABUSE EPIDEMIC

PRESENTED

MARCH 22, 2016

Statement of Louis J. Milione
Deputy Assistant Administrator
Drug Enforcement Administration
Before the Committee on Oversight and Government Reform
United States House of Representatives
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INTRODUCTION

Chairman Chaffetz, Ranking Member Cummings, and Members of the Committee: on behalf of the approximately 9,000 employees of the Drug Enforcement Administration (DEA), thank you for the opportunity to discuss our Nation's most pervasive drug issue of the day: the opioid overdose epidemic, spurred by nonmedical abuse of prescription opioids, heroin, and illicit fentanyl use. This is a problem that is worsening.¹

Drug overdoses are the leading cause of injury-related death in the United States, eclipsing deaths from motor vehicle crashes or firearms.² There were over 47,000 overdose deaths in 2014, or approximately 129 per day, over half (61%) of which involved either a prescription opioid or heroin.³ These are our family members, friends, neighbors, and colleagues.

According to the 2014 National Survey on Drug Use and Health (NSDUH), 6.5 million people over the age of 12 used psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives) for non-medical reasons during the past month. This represents 24 percent of the 27 million current illicit drug users and is second only to marijuana (22.2 million users) in terms of usage. There are more current users of psychotherapeutic drugs for non-medical reasons than current users of cocaine, heroin, and hallucinogens combined.⁴

Approximately 435,000 Americans reported past month use of heroin in 2014.⁵ The increase in the number of people using the drug in recent years – from 373,000 past year users in 2007 to 914,000 in 2014 – is troubling.⁶ The misuse of controlled opioid prescription drugs (CPD) and the growing use of heroin are being reported in the United States in unprecedented numbers. According to the United Nations' body that monitors treaty compliance, the International Narcotics Control Board (INCB), the United States consumes 78 percent of the

¹ Rose A. Rudd, Noah Aleshire, Jon E. Zibbell, R. Matthew Gladden. Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014 Morbidity and Mortality Weekly Report, 2016;64:1378-1382.

² Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS) [online], (2014), available at: <http://www.cdc.gov/injury/wisqars/fatal.html>.

³ Rose A. Rudd, Noah Aleshire, Jon E. Zibbell, R. Matthew Gladden. Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014 Morbidity and Mortality Weekly Report, 2016;64:1378-1382.

⁴ Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/>.

⁵ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014. Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2013 and 2014.

⁶ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality,

world's oxycodone and 99 percent of the world's hydrocodone⁷, despite having only five percent of the world's population.

CONTROLLED PRESCRIPTION DRUGS (CPDs)

In 2014, over 4.3 million Americans aged 12 or older reported using prescription pain relievers non-medically within the past month. This makes nonmedical prescription opioid use more common than use of any category of illicit drug in the United States except for marijuana. Whereas the vast majority of nonmedical opioid CPD users do not go on to use heroin, this information provides valuable insight into the role that CPDs play in the opioid epidemic and underscores the need to ensure that practitioners are educated on proper prescribing of CPDs.

Black-market sales for opioid CPDs are typically five to ten times their retail value. DEA intelligence reveals the “street” cost of prescription opioids steadily increases with the relative strength of the drug. For example, generally, hydrocodone combination products (a Schedule II prescription drug and also the most prescribed CPD in the country)⁸ can be purchased for \$5 to \$7 per tablet on the street. Slightly stronger drugs like oxycodone combined with acetaminophen (e.g., Percocet) can be purchased for \$7 to \$10 per tablet on the street. Even stronger prescription drugs are sold for as much as \$1 per milligram (mg). For example, 30 mg oxycodone (immediate release) and 30 mg oxymorphone (extended release) cost \$30 to \$40 per tablet on the street. The costs that ensue with greater tolerance make it difficult to purchase these drugs in order to support a developing substance use disorder, particularly when many first obtain these drugs for free from the family medicine cabinet or friends. Data from NSDUH show that chronic and frequent users are more likely than recent initiates to buy opioid drugs from a dealer.⁹ Not surprisingly, a small number of people who use prescription opioids non-medically – primarily those who are frequent nonmedical users or those with a prescription opioid use disorder - turn to heroin, a much cheaper opioid, generally \$10 per bag, which provides a similar “high” and can keep some individuals who are dependent on opioids from experiencing painful withdrawal symptoms. This cycle has been repeatedly observed by law enforcement agencies. For some time now, law enforcement agencies across the country have been specifically reporting an increase in heroin use by those who began using prescription opioids non-medically.¹⁰

Healthcare providers, as well as nonmedical users of CPDs are confirming this increase. According to some reporting by treatment providers, many individuals with serious opioid use

⁷ International Narcotics Control Board. March, 2015. “Report 2014: Estimated World Requirements for 2015—Statistics for 2013,” available at www.incb.org.

⁸ On October 6, 2014, DEA published a final rule in the *Federal Register* to move hydrocodone combination products from Schedule III to Schedule II, as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services.

⁹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013. Unpublished special tabulations (March 2015).

¹⁰ U.S. Department of Justice, Drug Enforcement Administration, 2015 National Heroin Threat Assessment Summary, DEA Intelligence Report, April, 2015, available at: http://www.dea.gov/divisions/hq/2015/hq052215_National_Heroin_Threat_Assessment_Summary.pdf.

disorders will use whichever drug is cheaper and/or available to them at the time.¹¹ Individuals who have switched to heroin are at high risk for unintentional overdose. Heroin purity and dosage amounts vary, and heroin is often cut with other substances (e.g. fentanyl), all of which could cause unintentional overdose because users simply cannot predict the dosage of opioid in the product they purchase on the street as heroin.¹² It should be noted as well that the same could be said of diverted or counterfeit prescription opioids purchased on the street.

Some CPD users become dependent on opioid medications originally prescribed for a legitimate medical purpose.¹³ Moreover, a Substance Abuse and Mental Health Services Administration (SAMHSA) study found that four out of five recent new heroin users had previously used prescription pain relievers non-medically (although a very small proportion (3.6%) of people who reported nonmedical use of prescription pain relievers had initiated heroin use within five years of initiating nonmedical use of pain relievers).¹⁴ The reasons an individual may shift from one opiate to another vary, but today's heroin is high in purity, and less expensive and often easier to obtain than illegal CPDs. High-purity heroin can be smoked or snorted, thereby circumventing a barrier to entry (needle use) and avoiding the stigma associated with injection. However, many who smoke or snort are vulnerable to eventually injecting. Heroin users today tend to be younger and more ethnically and geographically diverse than ever before.¹⁵

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

DEA RESPONSE TO THE NONMEDICAL USE OF CPDs

Nonmedical drug use cannot be addressed through law enforcement action alone. Any successful drug control strategy must be balanced and comprehensive, including a focus on both public health and public safety. It requires a coordinated effort by DEA together with our federal, state, and local government partners as well as private stakeholders.

¹¹ U.S. Department of Justice, Drug Enforcement Administration, 2014 National Drug Threat Assessment Summary, November, 2014.

¹² Stephen E. Lankenau, Michelle Teti, Karol Silva, Jennifer Jackson Bloom, Alex Harocopos, and Meghan Treese, Initiation into Prescription Opioid Misuse Among Young Injection Drug Users, *Int J Drug Policy*, Author manuscript; available in PMC 2013 Jan 1, Published in final edited form as: *Int J Drug Policy*, 2012 Jan; 23(1): 37-44. Published online 2011 Jun 20. doi: 10.1016/j.drugpo.2011.05.014. and; Mars SG, Bourgois P, Karandinos G, Montero F, Ciccarone D., "Every 'Never' I Ever Said Came True": Transitions From Opioid Pills to Heroin Injecting, *Int J Drug Policy*, 2014 Mar;25(2):257-66. doi: 10.1016/j.drugpo.2013.10.004. Epub 2013 Oct 19.

¹³ Pain, 2015 Apr; 156(4):569-76, doi: 10.1097/01.j.pain.0000460357.01998.f1, Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. Vowles KE1, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN.

¹⁴ Substance Abuse and Mental Health Services Administration, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, Department of Health and Human Services, and [August 2013], available at: <http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf>.

¹⁵ Cicero, T., Ellis, M., Surratt, H, Kurtz, S. The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years, July, 2014.

The Office of National Drug Control Policy's (ONDCP) 2011 Prescription Drug Abuse Prevention Plan, together with the 2014 National Drug Control Strategy and initiatives such as SAMHSA's Drug Free Communities program, comprise a multi-pronged approach that includes education, tracking and monitoring, proper medicine disposal, and enforcement, which represents a science-based and practical way to address this national epidemic.

Education of the Drug Supply Chain:

DEA provides education and guidance to registrants, professional associations, and industry organizations on current pharmaceutical diversion and nonmedical use, new and existing programs, policies, legislation, and regulations. In fiscal year (FY) 2014, DEA conducted over 150 such events. In FY 2015, DEA conducted 221 events, and for the first quarter of FY2016, DEA conducted 42 outreach and public education events raising the awareness of prescription drug abuse and the relationship to heroin, which reached thousands of DEA registrants, professional students, and the general public.

DEA, along with state regulatory and law enforcement officials, and in conjunction with the National Association of Boards of Pharmacy, hosts Pharmacy Diversion Awareness Conferences (PDACs) throughout the country. The conferences are developed and designed to address the growing problem of diversion of pharmaceutical controlled substances at the retail level. The conferences address pharmacy robberies and thefts, forged prescriptions, doctor shoppers, and illegitimate prescriptions from rogue practitioners. The objective of these conferences is to educate pharmacists, pharmacy technicians, and pharmacy loss prevention personnel on methods to prevent and respond to potential diversion activity. In FY2015, DEA hosted 14 PDACs in seven states. So far in FY2016, DEA has hosted eight PDACS in four different states. Ten additional PDACS are planned in five more states during this fiscal year. Since DEA began hosting the PDACS, over 10,000 pharmacy employees have been trained.

DEA has also routinely hosted its annual Manufacturers/Importers/Exporters Conference, with its most recent event culminating on September 23-24, 2015. This conference provides a forum to present federal laws and regulations that affect the pharmaceutical and chemical manufacturing, importing, and exporting industry and to discuss practices to prevent diversion while minimizing the impact on legitimate commerce. This event was attended by approximately 300 individuals representing this subset of DEA registrant community.

DEA also established its Distributor Initiative Program in 2005 to educate this registrant population on maintaining effective controls against diversion, and monitoring for and reporting suspicious orders. This program was initially designed to educate wholesale distributors who were supplying controlled substances to rogue Internet pharmacies and, more recently, to diverting pain clinics and pharmacies. The goal of this educational program is to increase distributor awareness and vigilance so that they cut off the source of supply to these and other schemes. Wholesale distributors are required to design and operate a system that will detect suspicious orders and report those suspicious orders to DEA. Through the Distributor Initiative Program, DEA educates distributors about their obligations under the Controlled Substances Act (CSA), as well as provides registrants with current trends and "red flags" that might indicate that

an order is suspicious. The Distributor Conference was recently held on April 15-16, 2015, and consisted of approximately 265 industry leaders from over 130 companies.

DEA will continue to engage with and educate industry. On February 29, 2016, DEA's Office of Diversion Control hosted a meeting with the leadership of drug supply chain trade associations to discuss areas of mutual concern.

Monitoring

Prescription drug monitoring programs (PDMPs) are typically State-run electronic database systems used by practitioners, pharmacists, medical and pharmacy boards, and law enforcement but access varies according to state law. These programs are established through state legislation and are tailored to the specific needs of a particular state. DEA strongly supports PDMPs and encourages the use of these programs by medical professionals in detecting and preventing doctor shopping and other diversion. Currently, 49 states have an operational PDMP (meaning collecting data from dispensers and reporting information from the database to authorized users).

While PDMPs are valuable tools for prescribers, pharmacists, and law enforcement agencies to identify, detect, and prevent nonmedical prescription drug use and diversion, PDMPs do have some limits in their use for detecting diversion at the retail level. For example, the use of PDMPs is limited across state lines because interconnectivity remains a challenge, as many drug traffickers and drug seekers willingly travel hundreds of miles to gain easy access to unscrupulous pain clinics and physicians.

We and our federal partners are working to address these problems. SAMHSA funds grants to improve interoperability between PDMPs and Electronic Health Record (EHR) technology and provide real-time provider access. ONDCP and the Bureau of Justice Assistance (BJA) also offer assistance for interstate and state-tribal PDMP linkages. We also understand that CDC supports work in 16 states to enhance and maximize PDMPs as public health and clinical tools in its *Prevention for States* program. Further, the Alliance of States with Prescription Drug Monitoring Programs, Brandeis University's PDMP Center of Excellence, and the Indian Health Service are also partnering to improve interoperability between IHS, its pharmacies and PDMPs. The National Association of Boards of Pharmacy (NABP) hosts NABP Prescription Monitoring Program (PMP) InterConnect, which facilitates the transfer of PDMP data across state lines to authorized users. The program allows users of participating PMPs to securely exchange prescription data between certain states. As of February 2016, 37 states have executed MOUs to participate in NABP's InterConnect program, and 31 of these states are currently live.

These programs, however, are only as good as the data that is in each system and the willingness of practitioners and pharmacists to use such systems on a consistent basis. At least Kentucky,¹⁶ New Jersey,¹⁷ New Mexico,¹⁸ New York,¹⁹ Oklahoma,²⁰ and Tennessee²¹ require all

¹⁶ Kentucky 201 KAR 9:260. 2012. Available at <http://www.lrc.ky.gov/kar/201/009/260.htm>

¹⁷ P.L. 2015, c.74 (N.J. 2015), available at http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF

controlled substance prescribers to use the state's PDMP prior to prescribing a controlled substance.²² DEA encourages all practitioners and pharmacists to use their state PDMP program.

Medication Disposal

On September 9, 2014, DEA issued a final rule, titled "Disposal of Controlled Substances." These regulations implement the Secure and Responsible Drug Disposal Act of 2010 and expand upon the previous methods of disposal by including disposal at drop-boxes in pharmacies and law enforcement agencies, mail back programs and drug deactivation systems if they render the product irretrievable. Through these regulations, DEA continues to focus its national attention on the issue of nonmedical use of prescription drugs and related substance use disorders (SUDs), and promotes awareness that one source of these drugs is often the home medicine cabinet, as 50.5% of persons aged 12 or older who used pain relievers non-medically in the past year got the pain relievers from a friend or relative for free²³, and provides a safe and legal method for the public to dispose of unused or expired CPDs.

Since 2010 DEA has held its National Drug "Take Back" Initiative (NTBI) to provide a convenient and safe option to dispose of unused, expired and/or unwanted prescription drugs. DEA's most recent NTBI was held on September 26, 2015. As a result of all ten National Take Back Days, DEA, in conjunction with its state, local, and tribal law enforcement partners, has removed a total of 5.6 million pounds (2,789 tons) of medications from circulation. The next National Drug Take Back Day is scheduled for April 30, 2016.

Enforcement: Tactical Diversion Squads

DEA Tactical Diversion Squads (TDSs) investigate suspected violations of the CSA and other Federal and state statutes pertaining to the diversion of controlled substance pharmaceuticals and listed chemicals. These unique groups combine the skill sets of Special Agents, Diversion Investigators, and a variety of state and local law enforcement agencies. They are dedicated solely towards investigating, disrupting, and dismantling those individuals or organizations involved in diversion schemes (e.g., "doctor shoppers," prescription forgery rings, and practitioners and pharmacists who knowingly divert controlled substance pharmaceuticals). Between March 2011 and March 2014, DEA increased the number of operational TDSs from 37 to 69.

¹⁸ New Mexico Register. 16.12.9.9. November 15, 2012. Available at http://www.nmcpr.state.nm.us/new-mexico-register/prev_issues/prev_issuesxxiii/xxiii21/16.12.9amend

¹⁹ New York 3343-A. 2012. Available at <http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a>

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

²¹ Tennessee 2253. 53-10-310. 2012. Available at <http://www.tn.gov/sos/acts/107/pub/pc0880.pdf>

²² PDMP Center of Excellence, Brandeis University. <http://www.pdmpexcellence.org/content/mandating-medical-provider-participation-pdmps>, retrieved September 30, 2015.

²³ Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health, Table 6.47B, Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older, by Age Group: Percentages, Annual Averages Based on 2011-2012 and 2013-2014.

Enforcement: Diversion Groups

When DEA was established in 1973, DEA regulated 480,000 registrants. Today, DEA regulates more than 1.6 million registrants. The expansion of the TDS groups has allowed Diversion Groups to concentrate on the regulatory aspects of enforcing the CSA. DEA has steadily increased the frequency of compliance inspections of specific registrant categories such as manufacturers (including bulk manufacturers); distributors; pharmacies; importers; exporters; and narcotic treatment programs. This renewed focus on oversight has enabled DEA to take a more proactive approach to educate registrants and ensure that DEA registrants understand and comply with the CSA and its implementing regulations.

HEROIN AVAILABILITY TO THE U.S. MARKET

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

DEA has also seen a 62 percent increase in poppy cultivation in Mexico between 2013 and 2014, primarily in the State of Guerrero and the Mexican “Golden Triangle” which includes the states of Chihuahua, Sinaloa, and Durango. The increased cultivation results in a corresponding increase in heroin production and trafficking from Mexico to the United States, and impacts both of our nations by supporting the escalation of heroin use in the United States, as well as the instability and violence associated with drug trafficking in Mexico.

The majority of Mexican and Colombian heroin bound for the United States is smuggled into the United States via the SWB, and heroin seizures at the border have more than doubled, from 1,016 kilograms in 2010 to 2,188 kilograms in 2014.²⁴ During this time, the average seizure at the Border also increased from 2.0 kilograms to 3.5 kilograms. Most heroin smuggled across the border is transported in privately-owned vehicles, usually through California, as well as through south Texas. In 2014, more than half of U.S. Customs and Border Protection (CBP) heroin seizures at the Southwest Border were seized in the southern California corridors of San Diego and El Centro. The distribution cells and the Mexican and South American traffickers who supply them are the main sources of heroin in the United States today. The threat of these

²⁴ Drug Enforcement Administration, Unclassified Summary, 2015 National Drug Threat Assessment, Pg. 35, *available at*: <http://www.dea.gov/resource-center/dir-ndta-unclass.pdf>.

organizations is magnified by the high level of violence associated with their attempts to control and expand drug distribution operations.

DEA has become increasingly alarmed over the addition of fentanyl into heroin sold on the streets as well as the use of fentanyl analogues such as acetyl fentanyl. The more potent opioids like fentanyl²⁵ present a serious risk of overdose death for a user. In addition, this drug can be absorbed by the skin or inhaled, which makes it particularly dangerous for law enforcement, public safety, or health care personnel who encounter the substance during the course of their daily operations. On March 18, 2015, DEA issued a nationwide alert to all U.S. law enforcement officials about the dangers of illicit fentanyl and fentanyl analogues and related compounds. In addition, due to a recent spike in overdose deaths related to the use of acetyl fentanyl, on July 17, 2015, DEA used its emergency scheduling authority to place acetyl fentanyl in Schedule I of the CSA.

DEA RESPONSE TO THE HEROIN THREAT

Additional Resources in Fiscal Year 2017

DEA plays an important part in the U.S. government's drug control strategy that includes enforcement, treatment, and prevention. While there are complex issues affecting spikes in heroin use and overdoses, including prescription drug abuse, the same significant poly-drug trafficking organizations responsible for other illicit drug threats are also responsible for the vast majority of the heroin supply. Additionally, drug trafficking has a proven linkage to gangs and other violent criminal organizations. Funding includes \$12.5 million and 42 positions, including 32 special agents, to create new enforcement groups in DEA domestic field divisions.

Heroin Task Force Program

As directed by Congress, the Department of Justice joined with ONDCP to convene an interagency task force to confront the growing use and trafficking of heroin in America. DEA and more than 28 Federal agencies and their components participated in this initiative. The task force provided its Report to Congress on December 31, 2015.

International Enforcement: Sensitive Investigative Units

DEA's SIU program, nine of which are in the Western Hemisphere, helps build effective and vetted host nation units capable of conducting complex investigations targeting major TCOs. DEA currently mentors and supports 13 SIUs, which are staffed by over 900 foreign counterparts. The success of this program has unquestionably enhanced DEA's ability to fight drug trafficking on a global scale.

²⁵ Centers for Disease Control, Emergency Response Safety and Health Database, FENTANYL: Incapacitating Agent, http://www.cdc.gov/niosh/erashdb/emergencyresponsecard_29750022.html, accessed March 19, 2015; U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drug & Chemical Evaluation Section, Fentanyl, March 2015.

International Enforcement: Bilateral Investigations Units

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

DEA'S 360 STRATEGY

DEA is rolling out the 360 Strategy to address the opioid, heroin, and violent crime crisis. The strategy leverages existing federal, state, and local partnerships to address the problem on three different fronts: law enforcement, diversion control, and community relations. The strategy is founded upon our continued enforcement activities directed at the violent street gangs responsible for feeding the heroin and prescription drug abuse epidemic in our communities.

While law enforcement plays a central role in the 360 Strategy, enforcement actions alone are not enough to make lasting changes in our communities. The 360 Strategy, therefore, also focuses on preventing diversion by providing education and training within the pharmaceutical community and to pursue those practitioners who are operating outside of the law. The final component of the strategy is a community effort designed to maximize all available resources to help communities turn around the recurring problems that have historically allowed the drug and violent crime problems to resurface after enforcement operations. Following is a summary of the three key facets of the 360 Strategy.

Enforcement: A commitment to stopping violence associated with drug trafficking

The enforcement component of the strategy is built around Rolling Thunder, a DEA-lead enforcement initiative, which targets the link between the cartels and violent gangs – these two elements have become the "New Face of Violent Crime." To execute the enforcement, DEA will rely upon all of its resources, including its Task Force Officers from local and state partners in the area.

The 360 Strategy will address the increased violence and drug trafficking on American streets. In the past, DEA would put its emphasis on working toward the Mexico-based organizations pushing drugs into the United States. As part of Rolling Thunder, DEA Agents will shut down the violent street gangs which regulate the drug trafficking business through the barrel of a gun.

Diversion: Enlisting DEA's Registrant Population in the Fight against Opioid Abuse

As stated above, the nonmedical use of prescription opioids is a strong risk factor for heroin use, and the 1.6 million registrants involved in the manufacture, wholesale distribution, and prescribing, are partners in our efforts to reduce opioid abuse.

DEA will engage with industry, practitioners, and government health organizations to facilitate an honest and frank discussion about the CPD abuse contributing to the current heroin epidemic. Additionally, DEA is studying ways, in collaboration with public health partners, to

improve access to information that will help identify the nature of the drug abuse problem plaguing a particular area.

Further, DEA will remain vigilant in identifying and pursuing prescribers and other registrants operating outside of the law. This process will be enhanced locally through the use of TDSs, which can mobilize to address regional or local issues, and additional diversion investigators.

Community: Leaving something lasting and positive in the communities we serve

After an enforcement operation targeting violent criminals, there's an opportunity for a prepared community to take advantage of the space and time created to better itself and prevent new traffickers from moving in.

This program enables communities to achieve long-term solutions by addressing not only the immediate drug-trafficking problems, but also the underlying conditions that allow drug trafficking, drug use and related violence to flourish. DEA will not only work with federal, state and local agencies to bring greater enforcement resources to bear, but also marshal community groups and their resources to identify local drug abuse problems, barriers to dealing with those problems and treatment solutions. DEA will partner with other federal agencies and sources of expertise and funding to broaden the resources available to the community.

The 360 Strategy is being implemented in four cities—West Memphis, Arkansas; St. Louis, Missouri; Pittsburgh, Pennsylvania; and, Milwaukee, Wisconsin—allowing us to gauge the success of the strategy, and to adjust the strategy as necessary in order to prepare for implementation nationwide. Our enforcement efforts will continue across the United States with our law enforcement and community partners.

CONCLUSION

The supply of heroin entering the United States feeds the increasing user demand for opioids. DEA will continue to address this threat by attacking the crime and violence perpetrated by the Mexican-based TCOs which have brought tremendous harm to our communities. DEA's 360 strategy will address the opioid and heroin epidemic with a multi-faceted approach, by stopping the violence associated with drug trafficking, and enlisting DEA's registrant community in the fight against opioid abuse. Additionally, DEA's Office of Diversion Control will work with DEA registrant community to address the prescription opioid side of this problem, and DEA will use all criminal and regulatory tools possible to identify, target, disrupt, and dismantle individuals and organizations responsible for violating the Controlled Substances Act. DEA will continue to work on the recommendations from the Heroin Task Force by developing a comprehensive strategy that will combine education, law enforcement, treatment and recovery, and a coordinated community response.

Louis J. Milione
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Special Agent Louis J. Milione was appointed to lead DEA's Office of Diversion Control as Deputy Assistant Administrator in October 2015. Mr. Milione acts as the principal advisor to the DEA Administrator, and DEA senior leadership on all matters pertaining to the regulation and coordination of worldwide programs associated with the diversion of legally produced controlled substances and listed chemicals. Mr. Milione is responsible for overseeing and coordinating major pharmaceutical and chemical diversion investigations; drafting and promulgating regulations; establishing drug production quotas; and conducting liaison with the pharmaceutical industry, international governments, state governments, other federal agencies, and local law enforcement agencies.

Prior to his appointment as Deputy Assistant Administrator, Mr. Milione served as the Assistant Special Agent in Charge of DEA's Bilateral Investigations Unit (BIU), which is part of DEA's Special Operations Division. The mission of the BIU, which is comprised of five extraterritorial enforcement groups, is to identify, infiltrate, indict, capture and convict in the United States, foreign based drug traffickers, narco-terrorists, money launderers and other transnational criminals that threaten U.S. National Security interests and impact global illicit networks.

For more than a decade, from Mr. Milione's selection as a founding member of the BIU in 2002, through his promotion to, and tenure as, Assistant Special Agent in Charge, Mr. Milione and his teams operated throughout Africa, Asia, Latin America and Europe, spearheading some of the U.S. Government's most sensitive and significant criminal investigations. Several examples include the indictment, capture and conviction of Russian arms trafficker Viktor Bout, Syrian narco-terrorist and Achille Lauro highjacking mastermind, Monzer Al Kassar; Afghan narco-terrorists, Haji Juma Khan, Haji Baghcho and Khan Mohammed, and the RICO indictment of the Norte Valle Cartel's leadership. In 2013, Mr. Milione led the high-risk investigation and arrest operation targeting corrupt current and former leaders of the narco-state Guinea Bissau, who were all indicted in the U.S. on drug trafficking and narco-terrorism charges. The defendants were lured onto an undercover vessel in international waters off the coast of Guinea Bissau, arrested without incident and transported to the U.S. where they are currently in custody.

Mr. Milione, who started with the DEA in 1997 as a Special Agent in New York City, has received numerous awards throughout his career including the Service to America Justice and Law Enforcement Medal (SAMMIE); the National Association of Police "Top Cop" award, and the Anti-Defamation League Leon and Marilyn Klinghoffer Memorial Award.

Mr. Milione is a graduate of Villanova University (BA-English) and the Rutgers School of Law (JD).