Department of Justice

STATEMENT OF

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BEFORE THE

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

FOR A HEARING CONCERNING

THE ESCALATION IN THE ABUSE OF HEROIN AND OTHER DANGEROUS DRUGS

PRESENTED

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Statement of Jack Riley
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Drug Enforcement Administration
Before the
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations
Committee on the Judiciary
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INTRODUCTION

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

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

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

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

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

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

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

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

CURRENT ASSESSMENT OF THE THREAT

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

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

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

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

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

AVAILABILITY OF HEROIN FOR THE U.S. MARKET

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

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

TRAFFICKING ALONG THE SOUTHWEST BORDER (SWB)

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

USE AND DEMAND

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

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

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

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

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

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

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

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

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

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

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

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

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

FENTANYL AND FENTANYL ANALOGUES

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

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

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

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

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

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

DEA's RESPONSE TO THE CURRENT HEROIN AND OPIOID THREAT

Anti-Heroin Task Force Program

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

International Enforcement: Sensitive Investigative Units

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

International Enforcement: Bilateral Investigations Units

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

Domestic Enforcement: Tactical Diversion Squads

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

Domestic Enforcement: Regulatory Investigations

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

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

National Drug Take Back Initiative (NTBI):

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

CONCLUSION

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