AN UNSECURE BORDER AND THE OPIOID CRISIS: THE URGENT NEED FOR ACTION TO SAVE LIVES

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON BORDER AND MARITIME SECURITY

OF THE

COMMITTEE ON HOMELAND SECURITY HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

MAY 30, 2018

Serial No. 115–67

Printed for the use of the Committee on Homeland Security

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

32–928 PDF WASHINGTON : 2018

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FOR THE RECORD

APPENDIX

AN UNSECURE BORDER AND THE OPIOID CRISIS: THE URGENT NEED FOR ACTION TO SAVE LIVES

Wednesday, May 30, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON BORDER AND MARITIME SECURITY,
Phoenix, AZ.

The subcommittee met, pursuant to notice, at 9:30 a.m., at Building 2 Virginia G. Piper Auditorium, University of Arizona College of Medicine—Phoenix, 550 E. Van Buren Street, Phoenix, AZ, Hon. Martha McSally [Chairman of the subcommittee] presiding.

Present: Representative McSally [presiding] and Lesko.

Also present: Representatives Grijalva, Schweikert, Sinema, and Gallego.

Ms. MCSALLY. The Committee on Homeland Security, Subcommittee on Border and Maritime Security, will come to order.

The subcommittee is meeting today to examine the impact an unsecure border has on the opioid crisis.

Before we proceed any further, as Chair I need to make a few important announcements.

It takes a tremendous amount of work putting this hearing together, and I appreciate the interest that is shown by the number of people who are in attendance today. I would also like to thank the University of Arizona for hosting us today and for allowing us to use this excellent facility.

Because this is an official Congressional hearing as opposed to a town hall meeting, we must abide by certain rules of the Committee on Homeland Security and the House of Representatives. I kindly wish to remind our guests today that demonstrations from the audience, including applause, verbal outbursts, as well as the use of signs or placards, are violations of the Rules of the House of Representatives. It is important to respect the decorum and the rules of the Committee.

I would also like to remind everybody that photography and cameras are limited to accredited press only.

I also ask unanimous consent that Mr. Schweikert, Ms. Lesko, Mr. Grijalva, Ms. Sinema, and Mr. Gallego be allowed to sit on the dais and participate in today's hearing. Without objection, so ordered.

I now recognize myself for an opening statement.

Opioid abuse has become an epidemic across the entire Nation, affecting all 50 States.

One hundred and fifteen Americans die every single day from an opioid overdose. These victims come from all walks of life. They are teachers, business professionals, ranchers, students, Government officials, and retirees. Here in Arizona there have been at least 800 lives lost just last year alone.

Some estimates conclude that more than 2 million of our fellow Americans are addicted to opioids. Chances are every single one of us knows someone struggling with opioid dependence. No State, no neighborhood, no socioeconomic group, no family is immune from the destruction and carnage that it brings.

Too many lives have been lost, too many families have been destroyed, and communities all over the Nation are asking what more can be done to stop this devastating opioid addiction epidemic?

I have called this hearing today to not only highlight the crisis but to discuss both law enforcement and non-law enforcement solutions that will ultimately save lives.

Thankfully, this is not a partisan issue.

I am grateful to see my colleagues here today, both Republicans and Democrats, so we can work together to identify the challenges and enact solutions to help families in our communities.

Actions to address this crisis will require multiple State, Federal, local, and Tribal governments to work together, in concert with non-profit entities and the faith-based community.

No one can go it alone, because this issue will require a whole-of-society approach.

Addiction often begins after powerful opioids are routinely prescribed out of a genuine need to manage pain after surgery. However, patients quickly become hooked, often unaware of how addicting they are.

In addition, even after the risks were well-known, unethical doctors continued to write prescription after prescription, becoming pill mills that now sustain the flow of opioids to those who are addicted.

Last year, four of Arizona's top opioid-prescribing doctors were located in the sparsely populated Mohave County. Together, they wrote prescriptions for nearly 6 million pills over a 12-month period.

An unsecure border enables and exacerbates this crisis by providing a strong supply of illicit versions.

Securing the border is more than just stopping illicit movement of people and contraband between the ports of entry, which is often the focus. But since I have been Chair of this subcommittee, I have also focused on modernizing infrastructure, technology, and additional manpower at our Nation's ports of entry. In fact, my first bill signed into law was fast-tracking our veterans for these critical manning positions at the ports.

It is well-known that the overwhelming majority of drugs, maybe as high as 90 percent, that enter our country come in through the Nation's ports of entry such as the ones in Nogales and Douglas. Illicit opiates are no exception.

Deep concealment within vehicles or in cargo is the preferred method of the drug cartels, and they are very successful despite the best efforts of the men and women of U.S. Customs and Border Protection.

To ensure the speedy movement of commerce that powers our economy, we can only X-ray a fraction of the vehicles and trucks that cross the border every day. We need more detection equipment and more tools for CBP to effectively combat the illicit drug flow hidden in legitimate travel and commerce.

I am proud to announce that I will be hosting the Secretary of Homeland Security, Secretary Nielsen, tomorrow at two of our ports of entry, Douglas and Nogales, so that she can see first-hand the needs that we have at these ports in Arizona.

I have been a tireless advocate for the expansion and modernization of Douglas not just because of its importance to economic growth, but because of its importance to security.

In addition to the challenges at the ports, fentanyl, an opioid 100 times stronger than morphine, is being produced illicitly in large quantities, chiefly in China, but also increasingly in Mexico. The primary smuggling route from China into the United States is through our mail system, where vulnerabilities in the postal system are exploited.

In order to mitigate these illicit pathways, we must secure the border and strengthen our postal system. In addition, we must increase the detection capabilities of law enforcement on every level as they respond to this disaster.

However, this is just one part of the solution. Law enforcement and increased border security alone will never be enough. We cannot enforce our way out of this problem.

We must also tackle this crisis with treatment and recovery options that help restore individuals to health and break the cycle of addiction.

Educating patients on the risks of taking properly prescribed opioids must be standard medical practice. With respect to those doctors who unethically prescribe these medications, they must be held accountable.

Most of all, we must support all those who suffer from addiction, their families and loved ones, to ensure that they get the help they so desperately need.

I am very proud to say that the State of Arizona has been a National leader in addressing these challenges head on.

Faced with a growing crisis, Governor Ducey declared the opioid crisis a public health emergency in June of last year. Then the Governor called a 4-day special session of the State legislature at the beginning of this year and signed the Arizona Opioid Epidemic Act.

The legislation takes aggressive steps to address opioid addiction, hold bad actors accountable, expand access to treatment, and provide life-saving resources to first responders, law enforcement, and community partners.

On the Federal level, Congress has been engaged in tackling this problem as well.

Legislation that passed the Homeland Security Committee and later became law provided additional fentanyl and synthetic opioids detection equipment to the front-line CBP officers in the INTERDICT Act.

Over the last few months, 57 bills that address this public health crisis are making their way through the House of Representatives.

These bills would provide new authority to: Spur urgently-needed research on new non-addictive pain medications; ensure medical professionals have access to a consenting patient's complete health history when making treatment decisions; provide resources for hospitals to develop protocols for discharging patients who have presented with an opioid overdose; establish comprehensive opioid recovery centers that will serve as models for comprehensive treatment and recovery; and direct the FDA to work with manufacturers to establish programs for efficient return or destruction of unused opioids.

The fiscal year 2018 appropriations bill provided over $4 billion in funding for the development of opioid alternatives, grants for States to respond to the challenge, new funds for equipment to inspect more incoming mail packages, as well as more X-ray devices at the ports of entry.

This is a complicated and multi-faceted problem. There are no quick or easy solutions. I have invited witnesses today who deal with this issue from many different angles to testify.

On the following panels we will hear from law enforcement and border security experts, as well as experienced professionals from the public sector, those with a family member or who were themselves addicted and found the support they needed to get and stay clean.

I look forward to the testimony from our witnesses today as we search for solutions to this grave crisis that affects too many of our fellow Americans.

[The statement of Chairwoman McSally follows:]

STATEMENT OF CHAIRWOMAN MARTHA MCSALLY

MAY 30, 2018

Opioid abuse has become an epidemic across the entire Nation, affecting all 50 States.

One hundred fifteen Americans die every single day from an opioid overdose. These victims come from all walks of life, they are teachers, business professionals, ranchers, students, government officials, and retirees. And here in Arizona there have been at least 800 lives lost just last year alone.

Some estimates conclude that more than 2 million of our fellow Americans are addicted to opioids. Chances are every single one of us knows someone struggling with opioid dependence.

No State, no neighborhood, no socioeconomic group, no family is immune from the destruction and carnage that it brings.

Too many lives have been lost, too many families have been destroyed, and communities all over the Nation are asking what more can be done to stop this devastating opioid addiction epidemic?

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In addition, even after the risks were well-known, unethical doctors continued to write prescription after prescription becoming "pill mills" that sustained the flow of opioids to those who are addicted.

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To ensure the speedy movement of commerce that powers our economy, we can only X-ray a fraction of the vehicles and trucks that cross the border every day. We need more detection equipment and more tools for CBP to effectively combat the illicit drug flow hidden in legitimate travel and commerce.

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I have been a tireless advocate for the expansion and modernization of the Douglas port of entry because our economic growth and National security rely on well-equipped ports.

In addition to the challenges at ports of entry, Fentanyl, an opioid about 100 times stronger than morphine, is being produced illicitly in large quantities, chiefly in China, but also increasingly in Mexico. The primary smuggling route from China and into the United States is through our mail system, where vulnerabilities in the postal system are exploited.

In order to mitigate these illicit pathways, we must secure the border and strengthen our postal system. In addition, we must increase the detection capabilities of law enforcement, on every level, as they respond to this disaster.

However, this is just one part of the solution. Law enforcement and increased border security alone will never be enough.

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Educating patients on the risks of taking properly prescribed opioids must be standard medical practice. With respect to those doctors who unethically prescribe these medications, they must be held accountable.

And most of all, we must support those who suffer from addiction, their families, and loved ones—to ensure that they can get the help they so desperately need.

I am very proud to say that the State of Arizona has been a National leader in addressing the challenges of opioid abuse head-on.

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Over the last few months 57 bills that address this public health crisis are making their way through the House of Representatives. These bills would provide new authority to:

Spur urgently needed research on new non-addictive pain medications.

Ensure medical professionals have access to a consenting patient's complete health history when making treatment decisions.

Provide resources for hospitals to develop protocols for discharging patients who have presented with an opioid overdose.

Establish Comprehensive Opioid Recovery Centers that will serve as models for comprehensive treatment and recovery.

Direct the FDA to work with manufacturers to establish programs for efficient return or destruction of unused opioids.

And the fiscal year 2018 appropriations bill provided over $4 billion dollars in funding for the development of opioid alternatives, grants for States to respond to this challenge, new funds for equipment to inspect more incoming mail packages as well as more X-ray devices at ports of entry.

This is a complicated, and multi-faceted problem.

There are no quick, or easy solutions. I have invited witnesses who deal with this issue from many different angles to testify this morning.

On the following panels we will hear from law enforcement and border security experts, as well as experienced professionals from the public sector, those with a family member or were themselves addicted to opioids and found the support they needed to get and stay clean.

I look forward to the testimony from our witnesses today, as we search for solutions to this grave crisis that affects too many of our fellow Americans.

Ms. MCSALLY. The Chair now recognizes the gentleman from Arizona, Mr. Grijalva, for any statement you may have.

Mr. GRIJALVA. Thank you very much, Madam Chair, and my appreciation to all the panelists that are going to give testimony today and respond to the questions from my colleagues.

The subcommittee hearing that the Chair stated was entitled: "An Unsecure Border and the Opioid Crisis and the Urgent Need for Action to Save Lives." Saving lives indeed. With a daily death toll of 116 in this country from overdoses and increasing addiction and uses of opioids, both prescription and illicit, continues to grow in this country.

The deaths and addictions have shattered lives, shattered families, led to more incarcerations, and the economic and community losses are dire in not only the State of Arizona but across the country. It is tragic here, and it is tragic everywhere.

I believe, as the reason for this hearing, saving lives must be the focus.

I wondered, Madam Chair, why we don't have a top-level pharmaceutical CEO here to give testimony as to their role in igniting the demand and use of prescription opioids and what they are doing to assist us in stemming this demand and this use.

I hope that in this hearing, because the premise is to save lives, that we don't politicize the real crisis with fanciful demands and proclamations about walls that cost $30 billion, about maximum sentencing as a deterrent, including the death penalty, as was mentioned by the Attorney General, and spending all the time in this hearing blaming immigrants and undocumented people, including moms of children, as the cause for this crisis. I think leaving that rhetorical political posturing aside, it would be important to talk honestly and realistically about the demand and use, cause and prevention, and treatment.

The ports of entry where over 80 percent of seizures of opioids have occurred have been historically underfunded in terms of personnel, understaffed, with less than the optimum technology and infrastructure, as was outlined by the Chair, that is needed in that border.

Bipartisan letters have gone to Homeland Security, to this administration, by both senators and a bipartisan group of Congressmen from Arizona time and time again to ask for additional resources to deal with the people in blue with the same emphasis

that we are dealing with Border Patrol and ICE. Since 57 percent of the seizures in this country occur between San Diego and Tucson, it would only seem logical that that should be a focus.

I think we need a strategy that provides a singular focus on this issue, a strategy to deal with the organized and wealthy crime syndicates whose market is the United States of America, where 5 percent of the population consumes over 80 percent of the opioids, be it prescription or illegal.

Yes, saving lives hopefully is what this hearing is about. Securing the border with fanciful proclamations is not going to deal with this issue. If we are going to save lives, it is going to require hard work, it is going to require cooperation across lines and across political parties. I prefer to do that hard work.

At this point, Madam Chair, with the remaining time, I would yield to my colleague, Congresswoman Sinema, for the time left on my opening statement.

Ms. SINEMA. Thank you, Congressman Grijalva, for yielding a moment of time. Thank you to Chairwoman McSally for holding this field hearing.

Like all Arizonans, we share a commitment to a more secure border and to addressing the opiate crisis. Washington needs to get serious about taking action. In the past year, more than 8,000 Arizonans overdosed on opiates. Over 1,200 of those lives couldn't be saved.

Congresswoman McSally, we have worked together to help stop the flow of dangerous drugs into our communities. We have offered three bills together to identify the greatest threats to Arizona's border, improved deployment of new border technologies, and prevent spotters who facilitate illegal crossings. We have also worked across the aisle to support and pass the recent Government funding bill which invests billions in border security resources, including counter-drug missions, and in treatment, prevention, and law enforcement efforts targeting the opiate crisis.

It is important that we put politics aside so we can protect and help Arizona communities and families. Our work should support work at the State level to win this fight.

Recently I co-introduced the COMPASS Act with Republican Congressman Roskam to help doctors cut down on over-prescribing and to help Arizonans better manage their medications. My bipartisan bill, which is expected on the House floor in June, reinforces the great work done by Governor Ducey and the State legislature through the Arizona Opiate Epidemic Act. I look forward to continuing to work with everyone here today to protect our communities, secure our border, and address the opiate crisis.

Thank you, and I yield back.

Ms. MCSALLY. The gentle lady yields back.

Does the gentleman yield back?

Mr. GRIJALVA. I yield back.

Ms. MCSALLY. We are honored on our first panel today to have Governor Ducey. Governor Doug Ducey became the Governor of Arizona in January 2015. Previously he served as Arizona's 32nd State treasurer, a position he held since his appointment in January 2011. Mr. Ducey, Governor Ducey joined Proctor and Gamble and began a career in sales and marketing. Then he was trained

in management, preparing him for his role as a partner and CEO of Cold Stone Creamery. Governor Ducey also served as the Chairman of Arizona's State Board of Investment and State Loans Commission.

I now recognize Governor Ducey to testify.

STATEMENT OF HON. DOUGLAS A. DUCEY, GOVERNOR, STATE OF ARIZONA

Governor DUCEY. Chairwoman McSally, Congressman Grijalva, distinguished Members of the subcommittee, and other Members in attendance, thank you for this opportunity to appear before you to discuss one of the most significant public health and safety emergencies our Nation and the State of Arizona has faced in a generation, the opioid crisis and the interrelated priority of securing our Nation's borders.

Let's start with the need to secure the border.

From the earliest days in my administration, I have had the opportunity to spend time with Arizona's border sheriffs and numerous everyday residents, citizens, and ranchers in our border communities. The concerns they have expressed for their safety and security are real, and it is our job to listen and take action.

I am grateful for the strong partnerships our State has with local law enforcement, and we have established these as well with the U.S. Department of Homeland Security over these many years.

In 2015, Secretary of Homeland Security Jeh Johnson was in town helping to coordinate security efforts for the Super Bowl. We had such great success working together that I thought, why can't we continue this type of collaboration to also secure our border?

Working with that cooperative spirit in partnership with the Department of Homeland Security, in 2015 we established the Arizona Border Strike Force. This intra-agency team has, without a doubt, made Arizona and our entire country safer.

One example of many large-scale efforts by the Border Strike Force is Operation Organ Grinder, which resulted in the seizure of more than 4,000 pounds of marijuana and the arrest of 73 felons.

To date, the Border Strike Force has kept 15.3 million hits of heroin off our streets.

It is not just drugs. What began as a traffic stop in Cochise County led to the discovery of a juvenile runaway who was the victim of horrific sex trafficking crimes. The primary suspect was sentenced to 20 years in prison and will face a lifetime of supervised probation and sex offender registration.

We are grateful that the new administration has amplified these efforts even further. President Trump's deployment of the National Guard has brought additional boots on the ground to our border. They are needed and they are welcomed.

Both General John Kelly and current DHS Secretary Kirstjen Nielsen have not only visited our State to tour the border with me, but they have delivered on both support and resources. They are finally making Washington, DC listen. After recently visiting all four of our border counties, I can tell you that the residents in these communities could not be more grateful.

When it comes to the opioid epidemic, overdoses and deaths have indeed reached crisis levels. Last year alone, 800 Arizona moms,

dads, brothers, sisters, family members, and friends were claimed by this scourge. This is why we are all here today, from across the State and from both political parties, because we have all seen the consequences, and we all know this is not a partisan issue.

The collaborative process under which our plan was developed, with stakeholders from across the State, and the way Democrats and Republicans came together to pass it unanimously is an example to our Nation of what can be accomplished when we do put politics aside.

The public health state of emergency I declared last June began a process of collaboration between the Arizona Department of Health Services, law enforcement, hospitals, medical professionals, addiction specialists, and other community stakeholders to fight this crisis head on.

The declaration allowed us to collect information on opioid overdoses, deaths, cases of newborns experiencing withdrawal from opioids, and naloxone use on a 24-hour basis, something no other State has done.

From there, our Department of Health Services worked to analyze the data and identify solutions focused on prevention and treatment.

For Arizonans dealing with chronic pain and participating in a responsible treatment plan, we know how critical these medications are. So we made sure that they were involved every step of the way, too.

During a special session last January, we addressed every facet of this fight, from the need to protect Good Samaritans and end pill mills, right down to the physical packaging of the drugs themselves. In fact, all opioid prescription bottles in our State will now have red caps to alert patients to the high risk of these drugs and the need to keep them away from children.

One of our most significant accomplishments was a result of bipartisan collaboration to improve access to treatment with a $10 million investment that will help uninsured and underinsured people get the treatment they need.

Since declaring a State of emergency last June, we have come a long way. In fact, every directive I gave in that declaration has been completed.

New reporting and information-sharing procedures are now codified in policy and rule.

Almost 1,000 law enforcement officers State-wide have been trained to provide naloxone. We have also seen a 355 percent increase in the number of naloxone doses dispensed by pharmacists to communities.

Our health care institutions now have rules for opioid prescribing and treatment.

Arizona Opioid Prescribing Guidelines have been updated and distributed.

Our comprehensive Opioid Epidemic Act went into effect in Arizona on April 26.

The 12 recommendations of our Opioid Action Plan will be fully implemented by the end of June.

With these items completed, our emergency declaration has served its purpose.

That is not all the positive news we have to report.

March and April 2018 saw a 33 percent reduction in the number of opioid prescriptions State-wide compared to March and April 2017.

Since last June, we have seen a 38 percent increase in the number of people referred to behavioral health treatment from hospitals after an overdose.

Since July 2017, we have seen a 60 percent reduction in the number of patients potentially doctor shopping through our CSPMP threshold report.

Since this April, over 200 prescribers have utilized our newly-established Opioid Assistance and Referral Line to get expert advice on treating patients.

In addition, we have worked with 100 percent of Arizona's academic partners who train prescribers to develop a State-wide curriculum on opioid prescribing, treatment of opioid use disorder, and management of chronic pain. This could be implemented in our schools as early as this coming fall.

We have certainly made progress, but we know that this fight remains deadly and that it is far from over. Continuing to work with each other and across the aisle as we have done, I know this is a fight we can win.

Again, thank you for having me here today.

[The prepared statement of Governor Ducey follows:]

PREPARED STATEMENT OF DOUGLAS A. DUCEY

MAY 30, 2018

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- Almost 1,000 law enforcement officers State-wide have been trained to provide naloxone. We have also seen a 355 percent increase in the number of naloxone doses dispensed by pharmacists to communities.
- Our health care institutions now have rules for opioid prescribing and treatment.
- Arizona Opioid Prescribing Guidelines have been updated and distributed.
- Our comprehensive Arizona Opioid Epidemic Act went into effect on April 26.
- And the 12 recommendations of our Opioid Action Plan will be fully implemented by the end of June.

With these items completed, our Emergency Declaration has served its purpose. And that's not all the positive news we have to report:

- March and April 2018 saw a 33 percent reduction in the number of opioid prescriptions State-wide compared to March and April 2017.
- Since last June, we have seen a 38 percent increase in the number of people referred to behavioral health treatment from hospitals after an overdose.
- Since July 2017, we have seen a 60 percent reduction in the number of patients potentially doctor shopping through our CSPMP threshold report.
- And since this April, over 200 prescribers have utilized our newly-established Opioid Assistance and Referral Line to get expert advice on treating patients.
- In addition, we have worked with 100 percent of Arizona academic partners who train prescribers to develop a State-wide curriculum on opioid prescribing, treatment of opioid use disorder, and management of chronic pain. This could be implemented in our schools as early as this coming fall.

We have certainly made progress, but we know that this fight remains deadly and that it is far from over. Continuing to work with each other, and across the aisle as we have done, I know this is a fight we can win.

Thank you again for having me today.

Ms. MCSALLY. Thanks, Governor Ducey. I really appreciate it. I understand you have a hard stop in just a few minutes, but you are willing to graciously take some of our questions. In order to be mindful of your schedule, we will reduce the time that each member has to 2 minutes. That means short questions and allowing the time for answers.

You have taken bold action here in Arizona. We appropriated $4 billion this year at the Federal level. What else can the Federal Government do in order to support your efforts in Arizona?

Governor DUCEY. I am proud of the efforts that we were able to take in the State of Arizona on a bipartisan level in terms of urgency and action and thoughtfulness and thoroughness on the opioid epidemic. I do think a wide open and unprotected border is a reality in this State, and law enforcement efforts in coordination, along with health care professionals and prescribers who understand this epidemic and the scourge that we are fighting in the State, will help us continue to improve not only for Arizona but for the rest of the United States, which is where many of these drugs are transported through our State, unfortunately.

Ms. MCSALLY. Great. Thanks.

I am going to yield back for time.

The Chair now recognizes the acting Ranking Member, Mr. Grijalva.

Mr. GRIJALVA. Thank you very much.

Thank you, Mr. Governor, for being here, appreciate it very much.

The point of security that you made, and I noted in my opening statement that the overwhelming majority of seizures of opioids entering this country illegally happen at the ports of entry. There has been a persistent issue, especially in Tucson and the other ports of entry, a persistent issue of understaffing, a persistent issue of infrastructure and technology not being up-to-date, efforts time and time again.

As part of the security umbrella that you mentioned in your talk, where do you see ports of entry in this fight?

Governor DUCEY. Mr. Grijalva, I agree with you. I think this is an all-of-the-above solution that we need to bring to this. So it is not only the ports of entry and the brave men and women who wear the blue shirts in our Federal Government, it is also the border agents and the people that wear the green shirts.

You are talking about the amount of drugs that are seized at the ports of entry, and that is a fact. But what we don't know are about the drugs that are not seized and that are getting to our cities and streets and high schools across the country. Those are ones that are somehow either evading the technology that is at the ports of entry, or it is coming through the border.

So I would be for an all-of-the-above approach in terms of law enforcement.

Mr. GRIJALVA. I yield back, Madam Chair.

Ms. MCSALLY. The gentleman yields back.

The Chair now recognizes Mr. Schweikert for 2 minutes.

Mr. SCHWEIKERT. Governor Ducey, I always have to break the habit of not calling you Doug.

Look, your office has always been incredibly good reaching out to ours when we are working on the reimbursements, the mechanisms, the prior authorization, and we appreciate that because it is complicated, and for a lot of us here, my hunger is for a holistic approach. Yes, there is a problem on the border. Yes, there is a health care problem. There is a problem with the mail. How do we get our heads around something that is this complicated?

You said something that both brings me joy but I would love to understand. You were saying that in the beginning of this year, in a couple of those months, you were seeing almost a one-third fall. I know a couple of months is really hard to get data from, but do you have a perception of what are we doing right to actually create that one-third fall, and how do we do more of it?

Governor DUCEY. Thank you, Mr. Schweikert.

Mr. SCHWEIKERT. You can call me David.

Governor DUCEY. The same temptation, David.

I think this idea of our State legislature taking action on this, the people that you will hear after me who will provide testimony focusing on this epidemic, and understanding that these drugs, for someone who is in chronic pain, these can be a miracle solution. But the way that they were being distributed, the way that they were being sold, the way that they were being prescribed provided a tremendous problem in our State.

One thing I want to give credit to is to Secretary Jeh Johnson, because it was that cooperation that we saw when Arizona hosted the Super Bowl in 2015 that we could work together in partnership with the Federal Department of Homeland Security, and I want to credit President Trump and Secretary Nielsen, who is working with Colonel Frank Milstead, our border sheriffs and sheriffs across the State, along with local law enforcement.

I do think this is a holistic solution that we have to come at from a standpoint of not only the rule of law, but then the best medical practices in how we handle these prescription drugs, and other drugs. I know that fentanyl was mentioned. The rise and spike in heroin is a result of this opioid epidemic.

So this is an all-hands-on-deck. It is not just for border States, because it may be border States where these drugs come through, but they are being distributed all across our Nation.

Mr. SCHWEIKERT. Governor, forgive me. It is the tyranny of the clock.

I yield back.

Ms. MCSALLY. The gentleman's time has expired.

The Chair now recognizes Ms. Sinema for 2 minutes.

Ms. SINEMA. Thank you.

Governor Ducey, as you know, Medicaid ensures access to treatment and recovery services for 4 in 10 adults suffering from opioid addiction in Arizona. It is one of the reasons I voted against bills that threaten Medicaid benefits that more than 400,000 Arizonans count on via our AHCCCS program.

Could you tell us about the role that AHCCCS plays in your State-wide plan to ensure that Arizonans have access to the services and treatment that they need?

Governor DUCEY. Thank you, Ms. Sinema. Of course, AHCCCS in Arizona is a safety net for those that need it most and the most

vulnerable, but it is not just about Medicaid. As I mentioned, we added $10 million to help those that the Affordable Care Act left behind, those that were uninsured or underinsured; also with providing dollars for those that need health care inside of our prisons.

I am concerned with what is happening with the Affordable Care Act from the standpoint of providers that are in the State of Arizona. If we were to go back a decade ago, we would have had 24 providers available in our 15 counties. Today we have one provider available in 14 of our 15 counties. So this is something that I will challenge Congress to act on. It is something that as a Governor and as an AHCCCS department and a department of health services, we will be a partner in reforming what is necessary for access to affordable and accessible health care in Arizona.

Ms. SINEMA. Thank you.

Ms. MCSALLY. The gentle lady yields back.

The Chair now recognizes Ms. Lesko for 2 minutes.

Ms. LESKO. Thank you, Madam Chair.

Thank you, Governor Ducey. I had the privilege of serving with the Governor while I was in the State legislature, and I was on the health committee, so we actually got to listen to testimony on this very important issue of opiate addiction. I applaud you and the State legislature for your work on this. It is very important, a very devastating problem in Arizona and throughout our country.

I know that, if my memory serves me correctly, in the Senate Health Committee, one of the things that we did in the legislature and that you promoted was having pharmacists check a registry of sorts to make sure that the patient wasn't getting over-prescribed with opiates. I think, if I remember, it was a balancing act of not over-regulating pharmacists and doctors and that type of thing.

Can you update us on what transpired on that and what the success has been with that program?

Governor DUCEY. Sure. Thank you, Ms. Lesko. We miss you very much in the Arizona State legislature, but Arizona's loss has been our United States Congress' gain.

This focus on the use of technology has reduced doctor shopping. This was what was happening oftentimes with people that were addicted, and this is a different type of drug because it is found behind the pharmacy window.

The addition of the red caps that are there so that people understand that this is a medicine to be taken seriously, should not be available to children or left in medicine cabinets. I think while it has only been a few months, the trend is incredibly positive, and it is a result of these actions.

You will also have some experts that will follow me—Director Cara Christ, Debbie Moak—that helped put these regulations in place that would allow us to provide the best possible health care, but to protect Arizonans' health and safety. To lose 800 Arizonans in the last 16 months, those were avoidable deaths, far too many. Then Tim Roemer will also be testifying from a law enforcement perspective, and I do think it is that partnership of health care and law enforcement that can best address this epidemic to our country.

Ms. SINEMA. Thank you.

I yield back.

Ms. MCSALLY. The gentle lady's time has expired.

The Chair now recognizes Mr. Gallego for 2 minutes.

Mr. GALLEGO. Thank you, Madam Chair.

Governor, it is good to see you again.

Definitely one of my proudest moments was working with Governor Brewer and other Republicans to pass Medicaid expansion, something that I think has been beneficial to this State, especially our critical care hospitals in urban areas, as well as our rural areas, which also are being harder hit when it comes to the opioid epidemic.

What we have heard so far is that we need a whole Government approach to this. But at the same time, the actions of the Arizona government and some of your proposals are actually to diminish Medicaid expansion and try to get people off Medicaid when we just heard that many of them actually end up using Medicaid to deal with their addiction.

So what I am kind of trying to bring together is how can we fight opioid addiction, how can Arizona take it seriously while at the same time we are taking efforts to gut Medicaid?

I will give you a good example. One of the efforts that you are pushing is to deal with the retrospective Medicaid eligibility, RME, specifically if you are Medicaid-eligible and you go to a hospital, that hospital will not only treat you that day, make you Medicaid-eligible, you go back 3 months beyond that to actually be able to bring in funds for any type of fees that you incurred in the hospital, which is very important, as you know, for a lot of these rural hospitals. But under your proposal, you have actually asked to get rid of that.

So how are you balancing this out? Make me understand, if we are really serious about the opioid addiction on the enforcement side, how come we aren't actually dealing with it on the Medicaid side? Bring this all together.

Governor DUCEY. Well, I don't think these two issues are mutually exclusive. I think when you talk about the reform of Medicaid, I have been outspoken that I don't want to see any Arizonan have the rug pulled out from underneath them.

Now, I expressed the very real issue that we only have one provider in 14 of our 15 counties in the State of Arizona.

Mr. GALLEGO. That is ACA. Medicaid has nothing to do with that. Medicaid is separate from ACA.

Governor DUCEY. When we are trying to move people off of Medicaid into work and private insurance, I think that is a preferable structure when it can be done. We have had a growing economy here in the State of Arizona, so we have tried to put policies forward that would incent people to take employment so that they could have private insurance, and we will continue to do that.

Ms. MCSALLY. The gentleman's time has expired.

Mr. GALLEGO. Thank you.

Ms. MCSALLY. I thank the Governor for his testimony and the Members for their questions. The Members of the committee may have some additional questions for the witnesses. We would ask that you respond to these in writing.

With that, I will dismiss this first panel.

We will quickly take a recess. I request the Clerk prepare the witness table for the second panel.

[Recess.]

Ms. MCSALLY. Our first witness is Mr. Guadalupe Ramirez, who is the acting director of field operations for U.S. Customs and Border Protection in the Tucson Field Office. Previously he served as the assistant director of field operations trade, and oversaw cargo and agricultural operations within the Tucson Field Office. The Tucson Field Office annually collects $30 million in revenues and processes 380,000 commercial trucks that transport $20 billion in trade.

Scott Brown is a special agent in charge of Homeland Security Investigations, or HSI, in Arizona. Mr. Brown has oversight of the full spectrum of Immigration and Customs Enforcement, or ICE, investigative activities in the State of Arizona. He has more than 500 personnel assigned to offices in Phoenix, Tucson, Douglas, Nogales, Yuma, Costa Grande, and Flagstaff.

Doug Coleman is the special agent in charge of the DEA's Phoenix Field Division. In this position, Special Agent Coleman is responsible for the leadership and management of all DEA operations in the State of Arizona. A 27-year veteran of the DEA, Special Agent Coleman began his law enforcement career in 1988.

Mr. Tim Roemer—did I pronounce that correctly? Tim Roemer currently serves as the State of Arizona's deputy director of homeland security and is Governor Ducey's public safety policy advisor. Prior to joining Arizona Department of Homeland Security, Mr. Roemer served in the Central Intelligence Agency for over 10 years.

I now recognize Director Ramirez to testify.

STATEMENT OF GUADALUPE RAMIREZ, ACTING DIRECTOR OF FIELD OPERATIONS, U.S. CUSTOMS AND BORDER PROTECTION—TUCSON, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. RAMIREZ. Thank you, Chairwoman McSally, Ranking Member Grijalva, and distinguished Members of the——

Ms. MCSALLY. Can you pull the microphone a little closer so we can hear? Thank you.

Mr. RAMIREZ. How about there?

Ms. MCSALLY. Thank you.

Mr. RAMIREZ. Chairwoman McSally, Ranking Member Grijalva, and distinguished Members, thank you for the opportunity to appear today and discuss the role of U.S. Customs and Border Protection, CBP, in combatting the flow of illicit opioids, including synthetic opioids such as fentanyl, into the United States.

My name is Guadalupe Ramirez. I am the acting director of field operations for CBP's Office of Field Operations in Tucson.

Since I began my career in Government in 1985, I have worked to facilitate legitimate trade and travel and protect our borders. In my more than 30 years of Federal service, I have seen a great deal of change. I began serving in the Tucson Field Office in 2009. Since then, I have seen a marked increase in the volume and potency of drugs interdicted at the ports of entry by CBP. I have seen interdictions of heroin, methamphetamine, and fentanyl increase dramatically; 357 percent more heroin was seized in the Tucson Field

Office ports in 2017 than in fiscal year 2009. The number of heroin seizures has increased five-fold since 2009.

In fiscal year 2009, there were 23 heroin seizures at the Arizona ports, averaging 8.3 pounds each. In fiscal year 2017, there were 114 heroin seizures, averaging 10.1 pounds each. Today, heroin seizures are currently 28 percent ahead of last year's pace. Seizures of fentanyl in 1 year increased 458 percent from 2016 to 2017.

In the land border environment, my area of experience, smugglers use a wide variety of tactics and techniques to conceal drugs. CBP officers regularly find drugs taped to individuals' bodies, hidden inside vehicle seats, gas tanks, tires, dashboards, as well as commingled in commercial shipments and concealed in commercial conveyances.

Seizures like these often involve the use of technology, canines, or both. CBP officers utilize non-intrusive inspection equipment, NII, including Z-Portal, high-energy mobile, and gamma ray imaging systems to detect the illegal transit of synthetic drugs hidden in passenger vehicles, cargo containers, and other conveyances entering the United States.

Canine operations are also an invaluable component of CBP's counter-narcotics operations. For example, on May 1, 2018, a CBP narcotics detection canine at Nogales, Arizona port of entry alerted officers to almost 11 pounds of heroin wrapped around the mid-section of an individual entering the United States. The heroin had an estimated street value in excess of $188,000. Officers seized the drugs and turned the arrested subject over to Homeland Security Investigations.

We are also actively engaging with our Federal, State, local, Tribal, and international partners to streamline our counter-narcotics efforts. Tucson Field Office is actively engaged with the Joint Port Enforcement Group alongside Homeland Security Investigations to ensure higher rates of contraband prosecution by assigning CBP officers to HSI to assist with casework. By working together to respond to, investigate, and prosecute illicit contraband seizures at the Arizona ports of entry, prosecution rates have increased to 97 percent.

We are also working with the government of Mexico in implementing unified cargo processing at commercial facilities in Nogales, Douglas, and San Luis. This brought Customs inspectors from Mexico into U.S. commercial facilities for joint processing and joint inspection of cargo coming from Mexico. Currently, 16 percent of all commercial cargo processed at the Arizona ports of entry is tied to this program, with expectations for increase. This has significantly changed cargo processing and is considered a best practice along the Southwest Border ports.

In coordination with our partnership, and with the support of Congress, we will continue to refine and enhance the effectiveness of our detection and interdiction capabilities to prevent the entry of opioids and other illicit drugs into the United States.

Chairwoman McSally, Ranking Member Grijalva, and distinguished Members, thank you for the opportunity to testify today. I look forward to your questions.

[The prepared statement of Mr. Ramirez follows:]

PREPARED STATEMENT OF GUADALUPE RAMIREZ

MAY 30, 2018

INTRODUCTION

Chairwoman McSally, Ranking Member Vela, and distinguished Members of the subcommittee, thank you for the opportunity to appear before you today to discuss the role of U.S. Customs and Border Protection (CBP) in combating the flow of dangerous opioids, including synthetic opioids such as fentanyl and fentanyl analogues, into the United States. The opioid crisis is one of the most important, complex, and difficult challenges our Nation faces today, and President Trump ordered the declaration of a National Public Health Emergency to address the opioid crisis in October of last year.[1]

As America's unified border agency, CBP plays a critical role in preventing illicit narcotics, including opioids, from reaching the American public. CBP leverages targeting and intelligence-driven strategies, and works in close coordination with our partners as part of our multi-layered, risk-based approach to enhance the security of our borders and our country. This layered approach reduces our reliance on any single point or program, and extends our zone of security outward, ensuring our physical border is not the first or last line of defense, but one of many.

OPIOID TRENDS, INTERDICTIONS, AND CHALLENGES

In fiscal year 2018 to date, the efforts of Office of Field Operations (OFO) and U.S. Border Patrol (USBP) personnel resulted in the seizure of more than 545,000 lbs. of narcotics including over 38,000 lbs. of methamphetamine, over 35,000 lbs. of cocaine, and over 2,700 lbs. of heroin.[2] CBP seizures of illicit fentanyl have significantly increased from approximately 2 lbs. seized in fiscal year 2013 to approximately 1,131 lbs. seized by OFO and USBP in fiscal year 2017.[3] Approximately 1,218 lbs. of illicit fentanyl have already been seized in fiscal year 2018.[4] Fentanyl is the most frequently seized illicit synthetic opioid, but CBP has also encountered 18 fentanyl analogues.[5]

Illicit drug interdiction in the border environment is both challenging and complex. Drug Trafficking Organizations (DTOs) and Transnational Criminal Organizations (TCOs) continually adjust their operations to circumvent detection and interdiction by law enforcement, quickly taking advantage of technological and scientific advancements and improving fabrication and concealment techniques.

DTOs seek to smuggle opioids, most commonly heroin, across our land borders and into the United States at and between our Ports of Entry (POEs), and Mexican manufacturers and traffickers continue to be major suppliers of heroin to the United States.[6] The reach and influence of Mexican cartels, notably the Sinaloa, Gulf, and Jalisco New Generation Cartels, stretch across and beyond the Southwest Border, operating through loose business ties with smaller organizations in communities across the United States. The threat of these cartels is dynamic; rival organizations are constantly vying for control, and as U.S. and Mexican anti-drug efforts disrupt criminal networks, new groups arise and form new alliances.

Smugglers use a wide variety of tactics and techniques for concealing drugs. CBP officers regularly find drugs concealed in body cavities, taped to bodies, hidden inside vehicle seat cushions, gas tanks, dashboards, tires, packaged food, household and hygiene products, in checked luggage, and concealed in construction materials on commercial trucks. For example, during the weekend of May 4, 2018 CBP officers at Arizona's San Luis POE arrested two individuals in connection to separate failed drug smuggling attempts in personal vehicles. In the first case, CBP seized approximately 113 lbs. of methamphetamine, worth nearly $338,000, and approximately 5 lbs. of heroin, worth more than $86,000, which the officers discovered hidden

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[1] *https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-action-drug-addiction-opioid-crisis/*.

[2] *https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics*.

[3] *https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics*.

[4] *https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics*.

[5] These include: acetylfentanyl, butyrylfentanyl, β-hydroxythiofentanyl, α-methylacetylfentanyl, p-fluorobutyrylfentanyl, p-fluorofentanyl, pentanoylfentanyl (a.k.a. valerylfentanyl), 2-furanylfentanyl, p-fluoroisobutyrylfentanyl, n-hexanoylfentanyl, carfentanil, benzodioxolefentanyl, acrylfentanyl, 2,2′-difluorofentanyl, methoxyacetylfentanyl, benzoylfentanyl, cyclopropylfentanyl, and hydrocinnamoylfentanyl.

[6] Heroin is also sometimes transported by couriers on commercial airlines. Heroin intercepted in the international commercial air travel environment is from South America, Southwest Asia, and Southeast Asia.

throughout the vehicle. During a second vehicle inspection, CBP officers discovered nearly 35 lbs. of methamphetamine, worth almost $105,000, concealed in the vehicle's seats and rear door. CBP officers turned the drugs, vehicles, and arrested subjects over to U.S. Immigration and Customs Enforcement—Homeland Security Investigations (ICE–HSI).[7]

While most illicit drug smuggling attempts occur at Southwest land POEs, the smuggling of illicit narcotics in the international mail and express consignment courier (ECC) environments also poses a significant threat. Illicit narcotics can be purchased from sellers through on-line transactions and then shipped via the United States Postal Service (USPS) or ECCs. DTOs and individual purchasers move drugs such as illicit fentanyl and fentanyl analogues in small quantities, making detection and targeting a significant challenge. However, these are often significantly more potent and therefore more deadly than the shipments seized along the border. Follow-on investigations, which are conducted by ICE–HSI, are also challenging because these shippers are often not the hierarchically structured DTOs we encounter in other environments. To combat this threat, CBP operates within nine major international mail facilities (IMF) inspecting international mail arriving from more than 180 countries, as well as 25 ECC facilitates located throughout the United States.

Between the POEs, DTOs and TCOs strategically send smugglers to vulnerable spots along the Southwest Border with limited infrastructure and technology to gain access into the illicit drug market. CBP plays a key role in the DHS and U.S. Government strategy to combat TCOs at home and with our international partners. We must combat these criminal and drug trafficking organizations with a systematic approach to border security. Our approach includes interagency coordination, legislative reform, as well substantial investments in impedance and denial capabilities, surveillance technology, access and mobility, mission readiness, and personnel.

CBP RESOURCES AND CAPABILITIES TO DETECT, TARGET, AND INTERDICT OPIOIDS

CBP, with the support of Congress, has made significant investments and improvements in our drug detection and interdiction technology and targeting capabilities. These resources, along with enhanced information sharing and partnerships, are critical components of CBP's ability to identify and deter the entry of dangerous illicit drugs in all operational environments. Additionally, thanks to the support of Congress, the International Narcotics Trafficking Emergency Response by Detecting Incoming Contraband with Technology Act, or the INTERDICT Act, authorized the appropriation of $9 million to CBP to ensure that CBP has sufficient resources and personnel, including scientists and chemical screening devices, to enhance CBP's drug interdiction mission and provide for additional scientists to process lab tests expeditiously.

Advance Information and Targeting

An important element of CBP's layered security strategy is obtaining advance information to help identify shipments that are potentially at a higher risk of containing contraband. Under section 343 of the Trade Act of 2002 (Pub. L. No. 107–210), as amended, and under the Security and Accountability for Every Port Act or SAFE Port Act of 2006, (Pub. L. No. 109–347), CBP has the legal authority to collect key cargo data elements provided by air, sea, and land commercial transport companies (carriers), including ECCs and importers.[8] This information is automatically inputted into CBP's Automated Targeting System (ATS), a secure intranet-based enforcement and decision support system that compares cargo and conveyance information against intelligence and other enforcement data. CBP, in conjuncture with

[7] *https://www.cbp.gov/newsroom/local-media-release/san-luis-cbp-officers-seize–529k-meth-and-heroin*.

[8] Under TSA requirements, inbound international mail destined for the United States is treated similar to other cargo and subject to security controls. These security controls, which include screening for unauthorized explosive, incendiary, and other destructive substances or items in accordance with TSA regulations and security program requirements, are applied to international mail prior to transporting on aircraft at Last Point of Departure locations to the United States. 49 U.S.C. 44901(a) states: "The Under Secretary of Transportation for Security shall provide for the screening of all passengers and property, including United States mail, cargo, carry-on and checked baggage, and other articles, that will be carried aboard a passenger aircraft." Under 49 C.F.R. 1540.5, Cargo means property tendered for air transportation accounted for on an air waybill. All accompanied commercial courier consignments whether or not accounted for on an air waybill, are also classified as cargo. Aircraft operator security programs further define the terms "cargo". These requirements are not dependent on advance electronic manifest data, as provided by ECC operators and other participants in the Air Cargo Advance Screening (ACAS) pilot program.

our Federal and international partners, is working to expand the availability of advanced electronic data (AED) to enhance our targeting in the international mail environment as well.

At CBP's National Targeting Center (NTC), advance data and access to law enforcement and intelligence records converge to facilitate the targeting of travelers and items of cargo that pose the highest risk to our security in all modes of inbound transportation. The NTC takes in large amounts of data and uses sophisticated targeting tools and subject-matter expertise to analyze, assess, and segment risk at every stage in the cargo/shipment and travel life cycles. The NTC leverages classified, law enforcement, commercial, and open-source information in unique, proactive ways to identify high-risk travelers and shipments at the earliest possible point prior to arrival in the United States.

To bolster its targeting mission, the dedicated men and women of the NTC collaborate with critical partners on a daily basis including ICE–HSI, the Drug Enforcement Administration (DEA), the Federal Bureau of Investigation (FBI), members of the intelligence community, and the United States Postal Inspection Service (USPIS). Investigative case data is fused with CBP targeting information to bolster investigations targeting illicit narcotics smuggling and trafficking organizations. Moreover, NTC works in close coordination with several pertinent task forces including the Organized Crime Drug Enforcement Task Force, the High Intensity Drug Trafficking Areas, and the Joint Interagency Task Force–West, as well as the Department of Homeland Security's (DHS) Joint Task Forces (JTF).

Some of the precursor chemicals that can be used to synthesize fentanyl and fentanyl analogues are currently non-regulated and many have legitimate uses. However, CBP has sufficient authority to seize precursors if they can be identified as having illicit end-use intentions, including the production of illicit drugs. CBP targets precursor chemicals transiting the United States with destinations to Mexico and other countries. When these shipments are identified through interagency collaboration as having illicit end-use intentions, the shipments are offloaded for further inspection and enforcement action by external agencies such as DEA and ICE–HSI.

In addition to targeting illicit substances directly, CBP also targets related equipment such as pill presses and tablet machines. DEA regulates pill press/tablet machines and there is an ICE Diversion Coordinator assigned to the DEA Special Operations Division who oversees the investigations of pill press and tablet machine imports being diverted for illicit uses. The Diversion Coordinator works closely with the NTC to identify and target individuals importing and diverting pill presses and tablet machines to press fentanyl, fentanyl analogues, and other synthetic drugs into counterfeit pills. In fiscal year 2014, 24 seizures of pill presses and tablet machines were made by OFO. The number increased to 92 in fiscal year 2017.

Non-Intrusive Inspection Equipment

At our POEs and in the international mail and express consignment environments, CBP utilizes technology, such as non-intrusive inspection (NII), X-ray, and gamma ray imaging systems to detect the illegal transit of synthetic drugs hidden on people, in cargo containers, and in other conveyances entering the United States. Since October 2010, CBP has conducted more than 83 million NII examinations, resulting in more than 18,500 narcotics seizures, and more than $79 million in currency seizures. For example, on April 15, 2018 CBP officers at the Veterans International Bridge in Brownsville, Texas utilized NII technology to discover 12 lbs. of heroin and 1.3 lbs. of methamphetamine in a personal vehicle. The combined estimated street value of the narcotics from the seizure is $348,000. CBP officers seized the narcotics along with the vehicle, arrested the driver, and turned him over to the custody of ICE–HSI for further investigation.[9]

CBP is committed to continuing to improve its ability to interdict illicit narcotics and is currently joining with the DHS Science and Technology Directorate (S&T) to evaluate existing detection solutions, such as the Handheld Illicit Drug Explosives Trace Detector (HID–ETD) and the X-ray imaging contract, and to develop advanced capabilities through a prize challenge for inventors to create or modify existing technology capable of accomplishing this.

Canines

Canine operations are an invaluable component of CBP's counternarcotic operations. The CBP Canine Training Program maintains the largest and most diverse law enforcement canine training program in the country. At our Nation's POEs and

[9] *https://www.cbp.gov/newsroom/local-media-release/brownsville-port-entry-cbp-officers-seize-over-300k-heroin-and.*

at preclearance locations abroad, CBP officers utilize specially-trained canines for the interdiction of narcotics, firearms, and undeclared currency, as well as in support of specialized programs aimed at combating terrorism and countering human trafficking. Concealed Human and Narcotic Detection Canines are trained to detect concealed humans and the odors of marijuana, cocaine, heroin, methamphetamine, hashish, ecstasy, fentanyl, and fentanyl analogues.

The use of canines in the detection of narcotics is a team effort. CBP's Laboratories and Scientific Services Directorate (LSSD) produces canine training aids and provides analytical support to the CBP Canine Training Program, including controlled substance purity determinations, pseudo training aid quality analyses, and research on delivery mechanisms that maximize safe vapor delivery during training exercises. Most recently, OFO's National Canine Program, in coordination with LSSD, assessed the feasibility of safely and effectively adding fentanyl as a trained odor to deployed narcotic detection canine teams. On June 23, 2017, the Office of Training and Development's CBP Canine Training Program successfully completed its first Fentanyl Detection Pilot Course. This added the odor of fentanyl and fentanyl analogues to 6 OFO canine handler teams in the international mail and ECC environments. Beginning October 1, 2018, all-new OFO canine handler teams graduating from the CBP Canine Training Program will have successfully completed a comprehensive CBP Canine Detection Team Certification to include the odor of fentanyl and fentanyl analogues. Today, all OFO Concealed Human and Narcotic Detection canine teams across all of OFO's operational environments have completed fentanyl training.

During fiscal year 2017, OFO canine teams were responsible for $26,813,863 in seized property, $1,905,925 in fines, $36,675,546 in seized currency, $29,674,839 in Financial Crimes Enforcement Network (FINCEN) actions, 197 firearms and 22,356 rounds of ammunition, 79 concealed humans, and 384,251 lbs. of narcotics. In fiscal year 2018 to date, OFO canine teams have been responsible for $7,322,522 seized property, $411,073 in fines, $7,951,376 in seized currency, $9,178,971 in FINCEN actions, 150 firearms, 5,418 rounds of ammunition, 105 concealed humans, and 187,409 lbs. of narcotics.[10]

For example, on May 1, 2018, a CBP Concealed Human and Narcotic Detection canine at the Nogales, Arizona POE alerted officers to almost 11 lbs. of heroin wrapped around the midsection of an individual entering the United States. The heroin had an estimated street value in excess of $188,000. Officers seized the drugs, and turned the arrested subject over to ICE–HSI.[11]

Laboratory Testing

As the narcotics seized through the international mail and at ECC facilities usually have a very high purity, CBP officers at IMFs and ECC facilities use various field testing devices to rapidly screen suspected controlled substances and obtain presumptive results. Using CBP's LSSD Field Triage Reachback Program, CBP officers can transmit sample data directly to LSSD for scientific interpretation and identification. When any synthetic opioids are detected by the Reachback program, LSSD notifies key CBP personnel at the NTC, as well as our liaisons at DEA. CBP is working to expand the field testing program, along with the scientific assets and personnel who are able to provide real-time chemical composition determinations.

In 2016, a CBP pilot program tested four hand-held tools and a new test kit to provide immediate presumptive testing for fentanyl. Based on the results of the pilot, OFO procured 12 systems for further testing across San Diego, Tucson, El Paso, and Laredo Field Offices. Last year, CBP purchased over 90 handheld analyzers for deployment. Handheld analyzers improve officer safety, and provides a near-real time capability to increase narcotic interdiction.

INFORMATION SHARING AND OPERATIONAL COORDINATION

Substantive and timely horizontal and vertical information sharing is critical to targeting and interdicting illicit drugs. CBP works extensively with our Federal, State, local, Tribal, and international partners and provides critical capabilities toward the whole-of-Government approach to address drug trafficking and other transnational threats at POEs, in our IMFs and ECCs, and along the Southwest Border, Northern Border, and coastal approaches. Our targeting, detection, and interdiction efforts are enhanced through special joint operations and task forces conducted under the auspices of multi-agency enforcement teams that target drug

[10] Effective 4/24/18.

[11] *https://www.cbp.gov/newsroom/local-media-release/nogales-cbp-officers-seize-188k-heroin.*

and transnational criminal activity, including investigations involving National security and organized crime.

Additionally, CBP hosts monthly briefings/teleconferences with Federal, State, and local partners regarding the current state of the border—the Northern Border and Southwest Border—to monitor emerging trends and threats and provide a cross-component, multi-agency venue for discussing trends and threats. The monthly briefings focus on drugs, weapons, and currency interdictions and alien apprehensions both at and between the POEs. These briefings/teleconferences currently include participants from: The government of Canada; the government of Mexico; ICE, U.S. Coast Guard (USCG); DEA; FBI; U.S. Northern Command; Joint Interagency Task Force–South; Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF); U.S. Attorneys' Offices; Naval Investigative Command; State and Major Urban Area Fusion Centers; and other international, Federal, State, and local law enforcement as appropriate.

CBP is a critical member in the S&T-led interagency Illicit Drug Detection Working Group. This Working Group assists in coordinating communications between various Government stakeholders inside and outside of DHS, including four other DHS components, the Department of Defense, DEA, and the Department of Justice (DOJ), on synthetic opioid information, such as seizure and profile data, and approaches for detection and best practices for safe handling. The Working Group, with the specific support of the National Institute of Standards and Technology, is also working on the development of detection standards for illicit drugs to allow the consistent test and evaluation of detection equipment and inform protocols for operational use. Further, these illicit drug detection standards generated by the Working Group will guide industry in their development of detection equipment that will meet the operational needs of DHS.

CBP is a key participant in the implementation of the Office of National Drug Control Policy's (ONDCP) Heroin Availability Reduction Plan (HARP). CBP also utilizes the DOJ's Nation-wide Deconfliction System operated by DEA, conducting interagency deconfliction and coordination, and is working with the Heroin and Fentanyl Working Group at the DEA Special Operations Division, alongside ICE–HSI.

Collaboration with our partners yields results. For example, the Chicago Field Office Tactical Analytical Unit initiated "Operation Mad Dog" in February 2017 to target international mail shipments suspected of containing illicit fentanyl and refer those shipments to law enforcement partners across the country—including ICE–HSI and State, local, and Tribal partners—for action. Targeted suspect shipments were intercepted and examined in IMFs based on information provided by our law enforcement partners and the NTC, as well as open-source information. Controlled deliveries have resulted in 37 arrests. Successes attributed to this operation to-date also include the seizure of over 57 lbs. of fentanyl, firearms, cash and crypto-currency, and the disruption of a major domestic dark web distributor of illicit fentanyl.

International Collaboration and Cooperation

USPS receives international mail from more than 180 countries. The vast majority of this mail arrives via commercial air or surface transportation. An increasing number of foreign postal operators provide AED to USPS, which is then passed on to CBP. CBP is working to expand the availability of AED globally to enhance the security of the international mail. For international mail arriving from foreign postal operators who do not provide AED, CBP officers utilize experience and training to identify items that potentially pose a risk to homeland security and public safety, while facilitating the movement of legitimate mail. CBP and USPS now have an operational AED targeting program at five of our main IMFs with plans for further expansion. USPS is responsible for locating the shipments and delivering them to CBP for examination. Thus far in fiscal year 2018, CBP has interdicted 186 shipments of fentanyl at the John F. Kennedy International Airport (JFK) IMF, a participant in the AED program. One hundred and twenty-five of those interdictions can be attributed to AED targeting. CBP and USPS continue to work with foreign postal operators to highlight the benefits of transmitting AED.

CBP, in close coordination with USPS and U.S. Food and Drug Administration, provided technical assistance on the "Synthetics Trafficking and Overdose Prevention (STOP) Act", which were largely incorporated into the pending "Securing the International Mail Against Opioids Act of 2018", which was recently reported favorably by the House Committee on Ways and Means. This legislation seeks to address these challenges in a multi-phase process which emphasizes risk-assessment, technology, and collaboration across the Federal Government and with our international partners. We support efforts to expand the ability of USPS to greatly increase the availability of AED (which is the foundation of a sound targeting mechanism) for

international mail, to develop new scanning technology, and to collect fees to help cover the cost of customs processing of certain inbound mail items.

Because DTOs are also known to use legitimate commercial modes of travel and transport to smuggle drugs and other illicit goods, CBP partners with the private sector to provide anti-drug smuggling training to air, sea, and land commercial transport companies (carriers) to assist CBP with stopping the flow of illicit drugs; to deter smugglers from using commercial carriers to smuggle drugs; and to provide carriers with the incentive to improve their security and their drug smuggling awareness. Participating carriers sign agreements stating that the carrier will exercise the highest degree of care and diligence in securing their facilities and conveyances, while CBP agrees to conduct site surveys, make recommendations, and provide training.

The trafficking of synthetic opioids like fentanyl and fentanyl analogues is a global problem, and CBP continues to work with our international partners to share information and leverage resources to combat this threat. CBP's Office of International Affairs International Technical Assistance Division (INA/ITAD) conducts International Border Interdiction training, coordinated and funded by the Department of State, for various countries world-wide. These courses provide instruction on multiple aspects of border security, including targeting and risk management, interdiction, smuggling, search methodologies, analysis, canine enforcement, and narcotics detection identification. INA/ITAD has conducted anti-smuggling training in opiate source countries such as Panama, Guatemala, Colombia, Ecuador, Peru, Mexico, Indonesia, India, Thailand, Afghanistan, Kenya, Cambodia, and the Philippines. CBP also provides an Identification of Drugs and Precursor Chemical training course to Mexico and other drug source and transit countries to provide important insight to foreign Customs Officers on the vast resources of precursors available to narcotics producers and traffickers world-wide.

Through the 21st Century Border Management Initiative, the U.S. Government and the government of Mexico are working to strengthen our collaborative relationship and efforts to secure and facilitate the cross-border flows of people and cargo. We receive information from Mexican authorities on a daily basis that helps us better target drug smugglers at the border and continue to work closely to expand joint efforts to combat illicit drug cultivation, production, and trafficking, and sharing more information on smuggling routes and networks. This information sharing, facilitated by the CBP attaché office in Mexico, has allowed for an unprecedented exchange of real-time information through deployments of personnel between our countries. Today, CBP personnel are assigned to Mexico City under the Joint Security Program where we exchange alerts on suspicious DTO movements through the monitoring of our Advance Passenger Information System. This information sharing has also led to numerous seizures and cases within Mexico that serve to disrupt the activities of DTOs throughout the Western Hemisphere.

CONCLUSION

In coordination with our partners and with the support of Congress CBP will continue to refine and enhance the effectiveness of our detection and interdiction capabilities to prevent the entry of opioids and other illicit drugs into the United States, including strengthening our ability to detect and interdict drugs entering via the mail and express consignment systems. Chairwoman McSally, Ranking Member Vela, and distinguished Members of the subcommittee, thank you for the opportunity to testify today. I look forward to your questions.

Ms. MCSALLY. Thank you, Mr. Ramirez.

The Chair now recognizes Mr. Brown to testify for 5 minutes.

STATEMENT OF A. SCOTT BROWN, SPECIAL AGENT IN CHARGE, HOMELAND SECURITY INVESTIGATIONS—PHOENIX, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. BROWN. Good morning, Chairwoman McSally, attendees from the Arizona congressional delegation. Thank you for the opportunity to appear before you today to discuss the opioid crisis in the United States, particularly along the border here in Arizona, and the efforts of U.S. Immigration and Customs Enforcement to target, investigate, disrupt, dismantle, and bring to justice the crimi-

nal elements responsible for the manufacturing, smuggling, and distribution of dangerous opioids.

As the largest investigative agency within the U.S. Department of Homeland Security, or DHS, ICE Homeland Security Investigations, or HSI, investigates and enforces more than 400 Federal criminal statutes. HSI special agents use their broad authority to investigate all kinds of cross-border criminal activity and work in close collaboration with U.S. Customs and Border Protection and the Drug Enforcement Administration in a unified effort with both domestic and international law enforcement partners to target transnational criminal organizations, or TCOs, that are supplying illicit substances to the United States.

Today I would like to highlight our efforts to reduce the supply of illicit opioids such as heroin and fentanyl from coming into the United States along the Southwest Border in Arizona and the operational challenges we encounter.

The United States is in the midst of an opioid epidemic that is being fueled by the smuggling and trafficking of heroin and illicit fentanyl. Based on our investigative efforts, U.S. law enforcement has identified China and Mexico as primary sources of the U.S. illicit opioid threat.

Illicit fentanyl, fentanyl analogues, and their immediate precursors are most often produced in China. From China, these substances are shipped primarily through mail carriers directly to the United States or are alternatively shipped directly to the TCOs in Mexico.

Once in the Western Hemisphere, often in Mexico, fentanyl or its analogues are mixed with other narcotics and fillers and/or pressed into pill form, then moved to the illicit U.S. market where demand for prescription opioids and heroin remain at epidemic levels.

Mexican cartels have seized upon the profit potential of opioids, including synthetic opioids, and seem to have invested in growing their share of this illicit market. We are even seeing an increased number of instances in which precursors originating in China and smuggled into the United States have traveled through the United States, destined for the Southwest Border locations to include here in Arizona. The Mexican cartels then attempt to smuggle the precursors out of the United States, allowing them to synthesize them into fentanyl in Mexico, with the intent to smuggle the finished product back into the United States for distribution and consumption. The final product is sold as heroin or as a prescription opioid, and the end-user may not be aware of the presence of fentanyl.

The vast majority of heroin and fentanyl entering and transiting Arizona is smuggled across the shared border with Mexico via the land border ports of entry. Like other narcotics supplied by Mexico, heroin and fentanyl are often smuggled utilizing deep concealment in passenger vehicles as the TCOs exploit the high volume of legitimate cross-border traffic at our ports of entry as part of the concealment of their smuggling efforts. Heroin and fentanyl loads are also smuggled by pedestrians into the U.S. ports of entry, often concealed on their person or in their bags or backpacks.

Almost all the Mexico-sourced drugs entering the United States via the border in Arizona can be attributed to the Sinaloa Cartel. HSI continues to investigate and identify the leadership of the

Sinaloa Cartel and attack the critical organizational nodes of smuggling facilitators and financial networks that sustain their operations. It is imperative that we continue to focus our efforts on disrupting and dismantling the Sinaloa Cartel, which not only smuggles opioids but other narcotics like methamphetamine and cocaine that also have a devastating impact on our communities.

HSI has made significant strides in fiscal year 2017 in combatting the fentanyl epidemic in the United States as evidenced by a 400 percent increase in fentanyl-related seizures. However, even with these advances, there is no single solution or Government entity that can stop the flow of dangerous and illicit opioids like fentanyl into the United States or keep them from harming the American public. Tackling this complex threat involves a united, comprehensive, and aggressive approach across law enforcement in collaboration with experts in the medical, science, and public health communities.

HSI will continue to work with our Federal, State, local, and Tribal partners to improve the efficiency of information sharing and operational coordination to address the challenges and threats posed by illicit narcotics smuggling into the United States.

Thank you for the opportunity to appear before you today. I will answer any questions you have.

[The prepared statement of Mr. Brown follows:]

PREPARED STATEMENT OF A. SCOTT BROWN

MAY 30, 2018

Chairman McSally, Ranking Member Vela, and distinguished Members: Thank you for the opportunity to appear before you today to discuss the opioid crisis in the United States, particularly along the border here in Arizona, and the efforts of U.S. Immigration and Customs Enforcement (ICE) to target, investigate, disrupt, and dismantle the criminal networks responsible for the manufacturing, smuggling, and distribution of dangerous opioids.

As the largest investigative agency within the U.S. Department of Homeland Security (DHS), ICE Homeland Security Investigations (HSI) enforces more than 400 Federal criminal statutes to include the Immigration and Nationality Act under (Title 8), U.S. Customs laws under (Title 19), general Federal crimes under (Title 18), and the Controlled Substances Act under (Title 21). HSI Special Agents use this authority to investigate all types of cross-border criminal activity and work in close coordination with U.S. Customs and Border Protection (CBP), the Drug Enforcement Administration (DEA), the United States Postal Inspection Service (USPIS) and our State, local, Tribal and international partners in a unified effort, to target the Transnational Criminal Organizations (TCOs) that are supplying illicit substances, to include opioids, to the United States.

Today, I would like to highlight our efforts to reduce the supply of illicit opioids, such as heroin, fentanyl, and fentanyl analogues from coming into the United States along the Southwest Border in Arizona and the operational challenges we encounter.

INTRODUCTION TO ILLICIT OPIOID SMUGGLING

The United States is in the midst of an opioid epidemic that is being fueled by the smuggling and trafficking of heroin, illicit fentanyl, and fentanyl analogues. Based on investigative efforts, United States law enforcement has identified China and Mexico as primary sources of the U.S. illicit fentanyl threat.

Illicit fentanyl, fentanyl analogues, and their immediate precursors are most often produced in China. From China, these substances are shipped primarily through international mail or express consignment carriers (such as DHL, FedEx, or UPS) directly to the United States or, alternatively, shipped directly, via express consignment, postal or commercial carriers to TCOs in Mexico. Once in the Western Hemisphere, fentanyl or fentanyl analogues are prepared and mixed with other narcotics and fillers and/or pressed into pill form, and then moved to the illicit U.S. market

where demand for prescription opioids and heroin remain at epidemic levels. In some cases, regional distributors smuggle industrial pill presses and components into the United States to operate fentanyl tableting operations domestically.

Mexican cartels have seized upon the profit potential of synthetic opioids, and seem to have invested in growing their share of this illicit market. Low cost coupled with high potency (one kilogram of fentanyl can be purchased in China for $3,000–$5,000) can generate upwards of $1.5 million in revenue on the illicit market. We are now seeing instances in which precursors originating in China and smuggled into the United States have traveled through the United States, destined for the Southwest Border locations, to include Arizona. The Mexican cartels have then smuggled the precursors out of the United States, synthesize them into fentanyl, and imported the finished product back into the United States for distribution and consumption. The final product may be advertised as heroin, and the end-user may not be aware of the presence of fentanyl.

ILLICIT OPIOID SHIPMENTS VIA INTERNATIONAL MAIL AND EXPRESS CONSIGNMENT FACILITIES

Though fentanyl seizures made at land border ports of entry are higher in number and larger in volume, the fentanyl seizures from mail and express consignment carrier (ECC) facilities are much higher in purity. Laboratory results of tested fentanyl has identified that the majority of illicit fentanyl seized in the international mail and ECC environments is shipped in concentrations of over 90 percent, whereas the majority of fentanyl in the land border port of entry environment is seized in concentrations of less than 10 percent. Illicit opioids like fentanyl can be purchased easily through open source and dark web marketplaces.

Just as TCOs attempt to hide illicit smuggling attempts at the land border ports of entry by blending into the voluminous daily legitimate cross-border traffic, TCOs are exploiting the great volumes of mail and parcels entering and crossing the United States as a means to conceal their criminal activity. In an effort to combat opioid trafficking through the mail and express consignments, HSI is targeting supply chain networks, coordinating with domestic and international partners, and providing field training to highlight officer safety, trends, and collaboration benefits with partners such as CBP, DEA, and the USPIS.

In April 2017, CBP officers assigned to an express consignment facility in Memphis, Tennessee intercepted a parcel from China found to contain more than two kilograms of a white powder, which after lab testing was found to be the fentanyl precursor 4–ANPP. The parcel was destined for a warehouse in Nogales, Arizona. The CBP officers coordinated with HSI special agents assigned to the Memphis Border Enforcement Security Task Force (BEST), who in turn coordinated with HSI Nogales to conduct a controlled delivery of the parcel. Through its investigative efforts, HSI Nogales identified the unwitting courier hired to pick up the parcel, and developed significant information about the organization in Mexico that was coordinating the smuggling effort. While this investigation is on-going, the intelligence developed from interviewing the courier about his likely conspirators has permitted HSI to impede operation of a precursor pipeline feeding fentanyl production in Mexico.

HSI is fully engaged with the DEA Special Operations Division (SOD) and the CBP National Targeting Center (NTC) to identify shipment routes and to target parcels that may contain illicit opioids and manufacturing materials. Full financial and investigative analyses are also conducted. While this is a good start, we recognize much more needs to be done.

Recognizing the need for greater action, HSI, CBP, and the USPIS are collaborating in the development of a more robust, Nation-wide effort to interdict illicit opioids transiting through mail facilities including by obtaining advanced data to improve our targeting. HSI is expanding the number of its trained investigators assigned to international mail facilities. These additional investigators will be seeking to conduct long-term, complex, criminal investigations into opioid trafficking activities, with the goal of achieving additional significant seizures and arrests. These seizures and arrests will help disrupt the movement of illicit opioids and opioid precursors transiting through the mail and ECCs, and will aid in the dismantling of distribution networks. The ultimate goal of course, is to reduce overdose deaths in the United States.

SMUGGLING OF FENTANYL AND HEROIN ACROSS THE ARIZONA/MEXICO BORDER

The vast majority of fentanyl and heroin entering or transiting Arizona is smuggled across the shared border with Mexico via the land border ports of entry. Like other narcotics supplied by Mexico, heroin and fentanyl loads are often smuggled

utilizing deep concealment within passenger vehicles, as the TCOs exploit the high volume of cross-border traffic at our ports of entry as part of their smuggling efforts. Heroin and fentanyl loads are also smuggled by pedestrians entering the United States at ports of entry, often concealed on their person, or in their bags or backpacks.

Loaded vehicles often contain multiple types of illicit drugs, which we refer to as "poly loads" or "mixed loads". It seems that the traditional drug supplying organizations have diversified their illicit product inventory to include increased amounts of heroin and fentanyl while also continuing to source methamphetamine, cocaine, and other drugs. HSI, as the investigative agency responsible for investigating smuggling at the ports of entry, works closely with CBP every day, to ensure that every smuggling incident is vigorously investigated, and expanded to the networks behind the smuggling attempt. Additionally, intelligence developed through HSI's investigative efforts is shared with CBP to enhance and refine their targeting and interdiction efforts at the ports of entry.

Almost all the Mexico-sourced drug supply entering the United States via the border in Arizona can be attributed to the Sinaloa Cartel. HSI continues to investigate and identify the leadership of the Sinaloa Cartel and attack the critical organizational nodes of smuggling facilitators and financial networks that sustain their operations. However, every law enforcement success against the cartels is challenged by the fact that the cartels are highly networked organizations with built-in redundancies that adapt on a daily basis based on their intelligence about U.S. border security and law enforcement. Mexican cartels, notably the Sinaloa Cartels, stretch across and beyond the Southwest Border, where they have strategically situated people in cities across the United States who have established networks and loose affiliations with smaller organizations for the purpose of smuggling.

Our vigorous response to these threats must include increased border security infrastructure, personnel, and technology; a system of systems if you will. Effective physical barriers, advanced technology, and strategic deployment of law enforcement personnel is essential, but it should be bolstered by interior enforcement and administration of our immigration laws in a manner that serves the National interest.

ICE'S COLLABORATIVE LINES OF EFFORT IN ARIZONA

There is no single entity or solution that can stop the flow of dangerous illicit drugs such as fentanyl and fentanyl analogues into the United States or keep them from harming the American public. Tackling this complex threat involves a united, comprehensive strategy and aggressive approach by multiple entities across all levels of government. Therefore, ICE, through its investigative arm, HSI, has long had inter-agency collaboration as one of its operational pillars. Law enforcement partnerships in Arizona are strong, and all agencies are committed to doing everything they can to defeat the heroin and fentanyl crisis that is gripping our Nation. Through partnerships across Arizona, across the Nation, and across the globe, HSI's commitment to collaboration is having a significant and positive impact.

Border Enforcement Security Taskforces (BESTs)

Border Enforcement Security Taskforces (BESTs) are DHS's primary platform to investigate opioid smuggling domestically. ICE currently operates BESTs in 62 locations throughout the United States. During fiscal year 2017, the number of BESTs increased 30 percent in response to the President's Executive Order 13773, *Enforcing Federal Law with Respect to Transnational Criminal Organizations and Preventing International Trafficking.* BESTs leverage the participation of more than 1,000 Federal, State, local, Tribal, and foreign law enforcement agents and officers representing over 100 law enforcement agencies to target opioid smuggling. In Arizona, HSI oversees 7 BESTs, one in each of all our front-line border offices: Douglas, Nogales, Sells, and Yuma, as well as Tucson, Casa Grande, and Phoenix. BESTs not only leverage the abilities and authorities of the participating agencies by unifying all under a single DHS effort; but they also provide a common case management and intelligence platform, which greatly increases the speed, completeness, and transparency of investigative and intelligence information sharing.

This level of information sharing is critical for combatting the TCOs that smuggle fentanyl and other drugs across the Arizona Border and distribute it in our heartland. The common case management and intelligence platforms enable the information obtained from a port seizure in Nogales, to be shared immediately with a BEST investigating a transportation cell in Phoenix, and a BEST investigating at a distribution network in Ohio.

So, to cite a real-world example, in support of an on-going investigation of a Nogales Sonora-based cell of the Sinaloa Cartel that smuggles opioids and other hard narcotics through the Nogales ports of entry, HSI agents and Maricopa County

Sheriff's Detectives were able to identify a recipient of the narcotics in Phoenix. During a traffic stop, the recipient was found to be in possession of 175 grams of fentanyl in pill form. Agents were also able to detain a package the recipient had dropped off at a post office, and working with U.S. postal inspectors, obtained a search warrant for the package, which was found to contain 1.3 kilograms of methamphetamine. HSI special agents were able to immediately and effectively coordinate with their counterparts in Little Rock, Arkansas, where the package was destined, and ultimately effected the arrest of the intended recipient. Both subjects have been charged Federally with Possession with Intent to Distribute Narcotics and Conspiracy to Possess and Distribute Narcotics.

Joint Port Enforcement Groups (JPEGs)

Across Arizona and now expanded across the Southwest Border, HSI and CBP have formed collaborative partnerships designated as Joint Port Enforcement Groups (JPEG) to more effectively address smuggling, to include opioid smuggling, at the ports of entry, while addressing staffing challenges and breaking down historical stovepipes. Under HSI supervision, CBP officers and Border Patrol agents have been trained on port response investigations. This ensures, particularly at remote ports of entry, that investigative efforts are started promptly, and information is shared quickly. The JPEGs also ensure clear and unfettered information sharing between ICE and CBP, breaking down historical barriers between DHS component agencies. This dramatically improves our ability to arrest and prosecute those who would attempt to smuggle opioids or other contraband into the country, while freeing up limited HSI resources to pursue more complex investigations targeting the entire smuggling network.

High Intensity Drug Trafficking Areas (HIDTAs)

Created by Congress through the Anti-Drug Abuse Act of 1988, the HIDTA program provides assistance to Federal, State, local, and Tribal law enforcement agencies operating in areas determined to be critical drug trafficking regions of the United States. The Office of National Drug Control Policy administers the HIDTA program, providing funding and working with Congress to designate localities eligible for the program. Like the BESTs, the HIDTA Task Forces ensure that the concerns of all the participating agencies, to include the State, local, and Tribal agencies, are included in investigative priorities; which certainly includes the impact of heroin and fentanyl on their communities. HSI works very closely with all Arizona HIDTA member agencies. In Nogales, HSI leads and houses the Santa Cruz County HIDTA Investigative Task Force.

On the Tohono O'Odham Nation, HSI houses and predominantly staffs the Native American Targeted Investigation of Violent Enterprises (NATIVE) Task Force. The HIDTA and NATIVE task forces then apply the full force of the participating agencies' authorities and abilities to disrupt and dismantle the threat. In collaboration with Border Patrol, and in close coordination with the U.S. Attorney's Office, the NATIVE Task Force has led a multi-layered initiative to disrupt and dismantle the extensive scouting and re-supply networks that have long enabled prolific smuggling in Arizona's West Desert Region. For years, law enforcement operating in the West Desert has been hampered by scouts for the drug cartels who sit on the highpoints and relay law enforcement movement to smuggling groups moving across the remote terrain. Challenges have included bringing effective prosecutions to the scouts, as they are geographically separate from the drugs they are helping to smuggle. By employing a comprehensive strategy, that identified and attacked the critical nodes that have made the West Desert one of the Nation's most notorious smuggling corridors, these on-going efforts have already resulted in a significant degradation to operations of the Sinaloa Cartel in the area.

Joint Task Force—West Arizona Corridor

HSI is a critical participant in the Joint Task Force—West (JTF–W)—to include in the Arizona Corridor. JTF–W is a collaborative effort across DHS components in support of the DHS Secretary's Southern Border and Approaches Campaign. In the Arizona Corridor, JTF–W conducts an annual cross-component threat assessment to ensure that DHS is aligning its resources and operating within a unity of effort to address cross-border threats, to include heroin and fentanyl smuggling.

Alliance to Combat Transnational Threats

The Alliance to Combat Transnational Threats is similar to the JTF–W, but expands the collaborative structure to include other Federal, State, local, and Tribal partners. Through this forum, joint operations to promote border security and counter the threat of smuggling are prioritized and planned. Additionally, intelligence and best practices are shared. One recent Unified Command meeting fea-

tured a presentation on personal protective equipment and fentanyl testing procedures to minimize the risk of exposure to fentanyl to law enforcement officers.

ICE'S USE OF COLLABORATION CENTERS OUTSIDE OF ARIZONA TO ATTACK THE THREAT IN ARIZONA

National Targeting Center—Investigations (NTC–I)

ICE HSI participates at CBP's NTC program through the National Targeting Center—Investigations (NTC–I), which leverages intelligence gathered during HSI investigations and exploits it using CBP data sets to target the flow of drugs into the United States. The NTC–I works to share information between CBP and ICE HSI entities world-wide.

ICE HSI has assigned special agents to work within the NTC Cargo (NTC–C) Narcotics Division. These special agents serve as liaisons between the NTC and ICE HSI personnel in both domestic and international posts. HSI investigative case data is fused with CBP targeting information to bolster investigations targeting illicit opioid smuggling and trafficking organizations. HSI and CBP in Arizona share all heroin and fentanyl seizure data and intelligence with the NTC to ensure the maximum exploitation of our combined efforts, more complete targeting, and more robust and impactful investigations. HSI in Arizona has consistently detailed special agents to the National Targeting Center to assist in these efforts.

NTC–I conducts post-seizure analysis based on ICE seizures in the field and CBP seizures at the ports of entry. The analysis is critical to identifying networks that transport illicit opioids throughout the United States. The resulting products are then shared with the affected HSI offices in the form of investigative leads. Another key component of the post-seizure analysis is the financial investigation. The NTC–I focuses on the financial element of the smuggling organization by exploiting information gathered from multiple financial databases.

Cyber Crimes Division

The ICE HSI Cyber Crimes Division provides support and assistance to field cyber investigations targeting dark net illicit marketplaces, where fentanyl and chemical precursors proliferate. This includes support to active investigations in Arizona. Recognizing the need to proactively target on-line opioid trafficking, the ICE HSI Cyber Crimes Division is identifying on-going investigations and facilitating the coordination of on-line and in-person undercover operations conducted in furtherance of dark net illicit marketplaces.

As criminal activity, and especially the trade of illicit opioids, continues to migrate to the on-line world, ICE HSI faces growing demand for cyber investigative assistance. Through the Human Exploitation Rescue Operative (HERO) program, the Cyber Crimes Division is training former warfighters to continue their service to the Nation in the field of computer forensics. HSI in Arizona currently has one HERO intern, and has converted four former HERO interns, all of whom completed their internships in Arizona, to full-time computer forensic agents to bolster our ability to fight cyber-enabled crimes.

Special Operations Division (SOD)

The DEA's Special Operations Division (SOD) Heroin and Fentanyl Task Force (HFTF) is supported by ICE, CBP, DEA, USPIS, and several other Federal agencies. The SOD-led, interagency task force exploits electronic communications to proactively identify, disrupt, and dismantle the production, transportation, and financial networks behind the heroin and illicit fentanyl distribution organizations that impact the United States.

The HFTF focuses on the collaborative authorities and efforts of each invested agency's resources, in order to better share and deconflict information. The HFTF works together to target international and domestic organizations by proactively working with field offices. The task force also assists in coordinating and linking investigations from the street-level dealer to the international supply source.

HSI in Arizona has consistently detailed special agents to SOD. These special agents advance the mission of SOD through their unique and in-depth knowledge of the Sinaloa Cartel. This expertise, honed through their investigative experience in Arizona, combined with the resources of SOD and the HFTF, contributes significantly to investigations, not only by HSI, but by other agencies, in Arizona and beyond.

Financial Division

Identifying, analyzing, and investigating the payment systems that facilitate the purchase and smuggling of opioids is critical to the disruption and dismantlement of networks that smuggle fentanyl and other illicit opioids into the United States.

ICE HSI conducts proactive investigations that focus on the two key payment systems, which support illicit procurement of opioids: Money service businesses (MSBs) and cryptocurrencies. Generally, illicit opioids that are purchased on the "indexed" internet are paid for through licensed mainstream MSBs. On dark net marketplaces and other "unindexed" websites, purchases are often paid for with cryptocurrencies such as Bitcoin. In support of its diverse financial investigative efforts, ICE HSI uses undercover techniques to infiltrate and exploit peer-to-peer cryptocurrency exchangers who typically launder proceeds for criminal networks engaged in or supporting dark net marketplaces. Furthermore, ICE HSI leverages complex Blockchain technology exploitation tools to analyze the digital currency transactions and identify users. Several HSI special agents assigned to Arizona have received Blockchain technology training which gives them the tools necessary to pierce the anonymity relied upon by dark net users.

ICE HSI created the Money Service Business Initiative to enable the application of advanced data analytics across large amounts of MSB data to isolate criminal networks, highlight suspicious transactions indicative of illicit activity, and provide predictive intelligence. The power of this type of advanced analytics truly shines when MSB data is integrated with additional Government data holdings, open-source and social media information, and communication records such as phone toll records, internet protocol (IP) address activity records, email search warrants, and Title III wire intercepts.

With support of its headquarters Financial Division and NTC, HSI in Arizona regularly pursues complex investigations of the cartels' exploitation of our legitimate financial systems, and the laundering and movement of their illicit proceeds via trade-based money laundering. Given the volume of legitimate trade between the United States and Mexico that occurs in Arizona, the ability to launder funds through the movement of goods versus dollars is a particular vulnerability here. In a joint effort to combat this threat, on May 25, 2017, on behalf of ICE HSI, I entered into a Memorandum of Understanding with the CBP Office of Field Operations, Tucson, officially launching the Nation's first land border Trade Enforcement Coordination Center in Nogales.

INTERNATIONAL COLLABORATION

ICE HSI in Arizona recognizes that all of our investigations have an international nexus. With ICE HSI's international presence of 67 offices in 50 countries, we are constantly looking to push our investigations beyond our borders. In Arizona this means near-daily collaboration with our ICE HSI attaché and assistant attaché offices in Mexico. Through strategic and targeted intelligence sharing, and joint investigative efforts, the impacts of our investigations are magnified. Whether through bi-national operations to arrest cartel leadership, or through sharing a piece of intelligence that may illuminate a previously unknown network, the building and strengthening of these partnerships is key to our efforts to combat the cartels and to stop threats, to include illicit opioids, before they reach our borders.

CONCLUSION

Thank you again for the opportunity to appear before you today and for your continued support of ICE HSI and its law enforcement mission. ICE HSI is committed to battling the U.S. opioid crisis. This includes ICE HSI's collaborative efforts to reduce and ultimately stop the flow of these dangerous drugs across the border here in Arizona and tackling the significant challenges we see in increased smuggling through the mail and express consignment systems. ICE HSI will continue to vigorously pursue the cartels that bring not only heroin and fentanyl to the United States, but other narcotics that have a dangerous, and too often deadly, impact on our communities. The opioid crisis is an epidemic that demands continued urgent and immediate action across law enforcement agencies and in conjunction with experts in the scientific, medical, and public health communities. I appreciate your interest in this important issue and look forward to your questions.

Ms. MCSALLY. Thank you, Mr. Brown.

The Chair now recognizes Mr. Coleman to testify for 5 minutes.

STATEMENT OF DOUGLAS W. COLEMAN, SPECIAL AGENT IN CHARGE, PHOENIX FIELD DIVISION, DRUG ENFORCEMENT AGENCY, U.S. DEPARTMENT OF JUSTICE

Mr. COLEMAN. Distinguished Members of the committee, on behalf of Acting Administrator Patterson and the men and women of

the Drug Enforcement Administration, I appreciate your invitation to testify today about the growing threat of opioid trafficking across the Southwest Border and the impact that these activities of narco-trafficking organizations are having on Arizona.

For DEA, the opioid crisis is and unfortunately will continue to be the top drug threat facing our Nation. This epidemic includes not only prescription opioid medications but also the proliferation of heroin, illicit fentanyl, and fentanyl analogues. Despite record numbers of overdose deaths, nearly 64,000 in 2016 alone, we are making progress on the prescription drug front. However, we are witnessing a fundamental shift toward cheaper, easier-to-obtain heroin and illicit fentanyl and its related analogues.

Over the last few years, Mexican drug cartels have exploited the increased demand for heroin and boosted their heroin production, transportation, and trafficking operations to get more heroin into the United States, predominantly across the Southwest Border. In addition, Chinese manufacturers began to produce fentanyl and fentanyl analogues and ship them to the United States via mail, or to Mexico, to be mixed into the U.S. domestic heroin supply, or pressed into a pill form and then moved to the illicit U.S. market where demand for prescription opioids and heroin remain at epidemic proportions.

More recently, Mexican DTOs are acquiring precursor chemicals and manufacturing fentanyl and its analogues to compete with the Chinese suppliers. The DEA in Arizona has been at the forefront of recognizing and responding to this increased heroin and fentanyl trafficking from the Mexican cartels. The Sinaloa Cartel is the primary drug threat to Arizona, as its organization influences and controls virtually all transportation and entry point importation along the Arizona-Mexico border. Additionally, the Sinaloa Cartel directs command-and-control cells in Phoenix and Tucson who are the choke points for both the drugs coming into the United States and the illicit proceeds returning to Mexico.

DEA's Phoenix Field Division's response has been multi-layered and comprehensive. No group in American law enforcement knows the Sinaloa Cartel and their operations better than the DEA in Arizona, and our strategy was developed based on this long-term knowledge of how this organization operates.

The first pillar of the strategy involves increasing our focus on the command-and-control cells operating in Phoenix and Tucson. These cells are often difficult to penetrate and require lengthy, complex investigations targeting communication facilities and cartel members who direct operations throughout the United States and coordinate with high-level cartel leadership in Mexico.

Working with our State, local, Tribal, and Federal partners, we have increased these types of complex conspiracy investigations targeting opiate trafficking by more than 60 percent over the last 3 years, resulting in the arrests of hundreds of high-level traffickers and the seizure of thousands of pounds of heroin and fentanyl, as well as the disruption and dismantlement of many of these cells.

The next pillar of our strategy was to increase our ability to directly support State and local law enforcement efforts targeting overdose deaths and community impact. To do this, we created a

Heroin Enforcement Action Team, or HEAT, to directly respond to local area opioid-related overdoses, attempting to expand overdose investigations to identify and target those directly responsible for supplying heroin/fentanyl to the overdose victims. By doing this, HEAT is a force multiplier to any State and local heroin investigation and allows us to target and bring to justice those individuals having the greatest negative impact in the local community.

Since its inception, the HEAT team has expanded to include relationships with over 40 governmental law enforcement agencies in Arizona and has arrested and prosecuted many individuals who were directly responsible for distributing opioids resulting in overdoses. The HEAT has been an incredibly beneficial program to local law enforcement, and we continue to expand both its footprint and operations throughout the State.

The final pillar of our strategy involves a robust and comprehensive public awareness and education campaign. In 2015 and 2017, we partnered with Arizona State University on two "Hooked" television specials about the dangers of heroin and diverted controlled prescription drugs that reached over 2 million Arizonans. We also conducted over 135 community outreach events over the past 3 years, educating thousands of Arizona residents about the dangers of heroin and opioid abuse. Finally, DEA officials have appeared on Arizona media—TV, radio, and newspaper—over 100 times in the past 3 years discussing the opioid addiction issue in a variety of forums.

While DEA in Arizona has a robust and comprehensive strategy to combat opioid abuse and trafficking in our State, we realize that our efforts, while having a significant impact and many successes, must be maintained and expanded to continue to best serve the citizens of Arizona and the United States. Rest assured that the men and women of DEA in Arizona will never relent, and we will continue to do everything in our power to do our part to help end this deadly epidemic.

On behalf of DEA, I thank the committee for the opportunity to speak today, and I am happy to answer any questions.

[The prepared statement of Mr. Coleman follows:]

PREPARED STATEMENT OF DOUGLAS W. COLEMAN

MAY 30, 2018

Chairman McSally, Ranking Member Vela, and 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 the threat posed by the flow of heroin, fentanyl, and fentanyl analogues across our borders, specifically in Arizona, and DEA's efforts, along with our Federal, State, and local partners, to combat this crisis.

Today, Mexican Transnational Criminal Organizations (TCOs) remain the greatest criminal drug threat to the United States; no other group can challenge them in the near term. These Mexican poly drug organizations traffic heroin, fentanyl, fentanyl analogues, methamphetamine, cocaine, and marijuana throughout the United States, using well-established transportation routes and distribution networks. They control drug trafficking across the Southwest Border (SWB) and are moving to expand their share of distribution and sales in U.S. domestic illicit drug markets, particularly heroin markets. At the same time, we face significant challenges with the emergence of fentanyl being hidden in the enormous volume of international parcel traffic by mail and express consignment couriers.

Drug overdoses, suffered by family, friends, neighbors, and colleagues, are now the leading cause of injury-related death in the United States, eclipsing deaths from

motor vehicle crashes or firearms.[1] According to the Centers for Disease Control and Prevention (CDC), there were nearly 64,000 overdose deaths in 2016, or approximately 174 per day. Over 42,200 (66 percent) of these deaths involved opioids. The sharp increase in drug overdose deaths between 2015 to 2016 was fueled by a surge in fentanyl and fentanyl analogues (synthetic opioids) involved overdoses.[2] Maricopa County is the most populated county in Arizona and encompasses the Phoenix metropolitan area. The Maricopa County Office of the Medical Examiner (MCOME) reported that in 2016 there were 647 overdose deaths while preliminary reporting for 2017 reflects an increase of opioid-related drug overdose deaths to 674. That number is expected to rise as toxicology reports are retuned and investigations finalized.

The incidence of misuse of controlled prescription drugs (CPDs) and the growing use of heroin, fentanyl, and fentanyl analogues are being reported in the United States at unprecedented levels. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2016 National Survey on Drug Use and Health (NSDUH), an estimated 6.2 million people over the age of 12 misused psychotherapeutic drugs (e.g., pain relievers, tranquilizers, stimulants, and sedatives) during the past month.[3] This represents 22 percent of the 28.6 million current illicit drug users, and is second only to marijuana (24 million users) in terms of usage.[4] There are more current misusers of psychotherapeutic drugs than current users of cocaine, heroin, and hallucinogens combined.[5]

The increase in the number of people using heroin in recent years—from 373,000 past year users in 2007 to 948,000 in 2016—is troubling.[6] More alarming is the proliferation of illicit fentanyl and fentanyl analogues. DEA investigations reveal that fentanyl and its analogues are increasingly being added to heroin and frequently pressed into counterfeit tablets resembling CPDs. Because of its high potency, the more illicit fentanyl and fentanyl analogues are introduced to the 11.5 million people that misused a pain reliever in the previous year, the more likely that drug overdoses will continue to climb.[7] In short, we are witnessing the transition from CPDs to heroin, fentanyl, and fentanyl analogues as the primary killer and peril within the opioid epidemic.

DEA's focus is targeting the most significant, sophisticated, and violent trafficking organizations that profit from exploiting persons with substance use disorders. DEA's strategic priorities include targeting Mexican Consolidated Priority Organization Targets (CPOTs) and Priority Target Organizations (PTOs), which are the most significant international and domestic drug trafficking and money-laundering organizations.

CONTROLLED PRESCRIPTION DRUGS (CPDS)

Black-market prices for sales of opioid CPDs are typically 5 to 10 times their retail value. DEA intelligence reveals the "street" cost of prescription opioids steadily increases with the relative strength of the drug. For example, hydrocodone combination products (a Schedule II prescription drug and also the most prescribed CPD in

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[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] CDC WONDER data, retrieved from the National Institute of Health website; *http://www.drugabuse.gov* as reported on NIDA's website.

[3] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17–5044, NSDUH Series H–52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/*.

[4] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17–5044, NSDUH Series H–52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/*.

[5] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17–5044, NSDUH Series H–52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/*.

[6] Center for Behavioral Health Statistics and Quality. (2017). 2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD

[7] Center for Behavioral Health Statistics and Quality. (2017). 2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD

the country)[8] can generally be purchased for $5 to $10 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 from friends.[9]

HEROIN

The vast majority of heroin consumed in the United States is produced and distributed by powerful Mexico-based TCOs, such as the Sinaloa Cartel and Jalisco New Generation Cartel, and transported to the United States across the Southwest Border. These TCOs are extremely dangerous, violent, and will continue to leverage established transportation and distribution networks within the United States.

Not surprisingly, some people who misuse prescription opioids turn to heroin. Heroin traffickers produce high purity white powder heroin that costs approximately $10 per bag, and usually contains approximately 0.30 grams per bag. This makes heroin significantly less expensive than CPDs. Heroin produces a "high" similar to opioid CPDs, and can keep some individuals who are dependent on opioids from experiencing painful withdrawal symptoms. For some time now, law enforcement agencies across the country have been specifically reporting an increase in heroin use by those who began misusing prescription opioids.[10]

According to 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.[11] Heroin purity and dosage amounts vary, and heroin is often adulterated with other substances (e.g., fentanyl and fentanyl analogues). This means that heroin users run a higher risk of unintentional overdose because they cannot predict the dosage of synthetic opioid in the product they purchase on the street as heroin.[12] Additionally, varying concentrations found in diverted or counterfeit prescription opioids purchased on the street have led to increased unintentional drug overdose deaths. Roughly 75 percent of heroin users reported nonmedical use of prescription opioids before initiating heroin use.[13] The reasons an individual may shift from one opioid to another vary, but today's heroin is high in purity, less expensive, and often easier to obtain than illegal opioid CPDs.

Overdose deaths involving heroin are increasing at an alarming rate, having increased more than fivefold since 2010.[14] Today's retail-level heroin costs less and is more potent than the heroin DEA encountered two decades ago. It is also not uncommon for heroin users to seek out heroin dealers claim is "hot," meaning it is likely cut with fentanyl or its analogues. Users seeking "hot" heroin is an indicator that as higher opioid tolerance levels develop, users will seek out ever more potent forms of opioids.

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[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] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17–5044, NSDUH Series H–52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/*.

[10] U.S. Department of Justice, Drug Enforcement Administration, 2016 National Heroin Threat Assessment Summary, DEA Intelligence Report, April 2016, available at: *https://www.dea.gov/divisions/hq/2016/hq062716_attach.pdf*.

[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 on-line 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: 110.1016/j.drugpo.2013.10.004. Epub 2013 Oct 19.

[13] Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. (2014). The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry*.71(7):821–826.

[14] CDC WONDER data accessed on 10/15/17, as reported at NIDA's website: 3,036 heroin overdoses in 2010; 15,446 overdoses in 2016. *https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.*

FENTANYL AND FENTANYL ANALOGUES

Fentanyl is a Schedule II controlled substance produced in the United States and widely used in medicine. It is an extremely potent analgesic indicated for use anesthesia and pain control in people with serious pain problems, and only for individuals who have high opioid tolerance.

Illicit fentanyl, fentanyl analogues, and their immediate precursors, are often produced in China. From China, these substances are shipped through private couriers or mail carriers directly to the United States, or alternatively shipped directly to TCOs in Mexico, Canada, or the Caribbean. Once in the Western Hemisphere, fentanyl or fentanyl analogues are prepared to be mixed into the U.S. domestic heroin supply, or pressed into a pill form, and then moved to the illicit U.S. market where demand for prescription opioids and heroin remain at epidemic proportions. In some cases, traffickers set up Chinese pill presses in the United States, and press fentanyl pills domestically. Mexican TCOs have also seized upon this business opportunity because of the profit potential of synthetic opioids, and have invested in growing their share of this illicit market. Because of its low dosage range and high potency, one kilogram of fentanyl purchased in China for $3,000–$5,000 can generate upwards of $1.5 million in revenue on the illicit market.[15]

According to the DEA National Forensic Laboratory Information System (NFLIS), from January 2013 through December 2016, over 58,000 fentanyl exhibits were identified by Federal, State, and local forensic laboratories.[16] During 2016, there were 36,061 fentanyl reports compared to 1,042 reports in 2013,[17] an exponential increase over the past 4 years. The consequences of fentanyl misuse are often fatal and occur amongst a diverse user base. According to a December 2017 CDC Data Brief, from 2015 to 2016, the death rate from synthetic opioids other than methadone, a category that includes fentanyl, doubled from 9,580 (age adjusted rate 3.1) to 19,413 (the age-adjusted rate of drug overdose deaths involving synthetic opioids other than methadone [drugs such as fentanyl, fentanyl analogs, and tramadol] doubled between 2015 and 2016, from 3.1 to 6.2 per 100,000).[18]

More disturbing is the production of fentanyl pills disguised as 30 milligram oxycodone pills. In 2017, over 100,000 such pills were seized in Arizona.[19] Alarmingly, intelligence reflects that traffickers may be changing their methods and pressing fentanyl into the form of other prescription drugs, as they have experienced success in disguising fentanyl as oxycodone. Fentanyl-related deaths have been reported in Florida where fentanyl was made to look like Xanax pills; and in California, where pills were made to look like Norco.[20] In addition to the fake oxycodone pills, 22 kilograms of fentanyl were seized in Arizona in calendar year 2016 and 125 kilograms were seized in calendar year 2017.[21] In July 2017, the first carfentanil seizure occurred in Arizona, by the Salt River Police Department, where 397 blue tablets were also designed to resemble pharmaceutically manufactured oxycodone.[22]

CURRENT ASSESSMENT OF THE THREAT

Threats at the Southwest Border

Based on active law enforcement cases, the following Mexican TCOs are operating in the United States: the Sinaloa Cartel, Beltran-Leyva Organization (BLO), Jalisco New Generation Cartel (Cartel de Jalisco Nueva Generación or CJNG), the Los Cuinis, Gulf Cartel (Cartel del Golfo or CDG), Juarez Cartel, La Linea, Michoacán Family (La Familia Michoacána or LFM), Knights Templar (Los Caballeros Templarios or LCT), and Los Zetas. While all of these Mexican TCOs transport wholesale quantities of illicit drugs into the United States, the Sinaloa Cartel remains the most active supplier and is the primary source for wholesale traffickers impacting Arizona. The Sinaloa Cartel leverages its expansive resources and organi-

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[15] U.S. Department of Justice, Drug Enforcement Administration, 2017 National Drug Threat Assessment Summary, October 2017.

[16] U.S. Department of Justice, DEA, NFLIS, actual data queried on October 13, 2017.

[17] U.S. Department of Justice, DEA, NFLIS, actual data queried on October 13, 2017.

[18] Rose A. Rudd, Noah Aleshire, Jon E. Zibbell, & R. Matthew Gladden, Hedegaard, H., Margaret Warner, and Arialdi M. Miñio. Drug Overdose Deaths in the United States, 1999–2016 Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014 Morbidity and Mortality Weekly Report NCHS Data Brief, 2016; 64:1378–1382 No. 294, Dec 2017. *https://www.cdc.gov/nchs/data/databriefs/db294.pdf.*

[19] EPIC National Seizure System.

[20] DEA Intelligence Brief/(U//FOUO) Counterfeit Prescription Pills Containing Fentanyls: A Global Threat—May 2016.

[21] EPIC National Seizure System.

[22] Joint Arizona HIDTAS/DEA Officer Safety/Situaltional Awareness Report—First Carfentanil Seizure in Arizona—May 2018.

zational structure in Mexico to facilitate the smuggling and transportation of drugs throughout the United States.

Mexican TCO operations in the United States typically take the form of a supply chain system that relies on compartmentalized operators who are only aware of their own specific function, and who remain unaware of other operational aspects. In most instances, transporters for the drug shipments are independent third parties who work for more than one Mexican TCO. Since operators in the supply chain are insulated from one another, if a transporter is arrested, the transporter is easily replaced and unable to reveal the rest of the network to law enforcement.

The foundation of Mexican TCO operations in the United States is comprised of extensive and well-entrenched transportation and distribution networks based throughout the United States. Frequently, members of Mexican TCOs are sent to important U.S. hub cities to manage stash houses containing drug shipments and bulk cash drug proceeds. While operating in the United States, Mexican TCOs actively seek to maintain low profiles and avoid violent confrontations with other, rival TCOs, or U.S. law enforcement.

Mexican TCOs transport illicit drugs over the SWB through ports of entry (POE) using passenger vehicles or tractor-trailers. In Arizona, the Nogales POEs are the primary entry points for heroin and fentanyl, and along with other drugs, are typically secreted in hidden compartments when transported in passenger vehicles, or comingled with legitimate goods when transported in tractor-trailers. Once across the SWB, Mexican TCOs will initially utilize stash houses in a number of hub cities, including Dallas, Houston, Los Angeles, Atlanta, Phoenix, and Tucson. The illicit products will then be transported via these same conveyances to distribution groups in the Midwest and on the East Coast. Mexican TCOs also smuggle illicit drugs across the SWB using other methods, including tunnels, maritime conveyances, aircraft, and body-carriers through pedestrian lanes at POEs.

Importation vs. Domestic Production and Use of the Internet

Fentanyl, fentanyl analogues, and other synthetics, are relatively inexpensive, available via the internet, and are often manufactured in China. From there, they may be shipped (via U.S. mail or express consignment couriers) to the United States, or alternatively directly to transnational criminal organizations in Mexico, Canada, and the Caribbean. Once in the Western Hemisphere, fentanyl and fentanyl analogues in particular are combined with both heroin or binders and pressed into counterfeit pills made to look like controlled prescription drugs containing oxycodone or hydrocodone, and then sold on-line from anonymous dark net markets and even overtly operated websites. The combination of: The questionable legal status of these substances, which are not specifically named in the Controlled Substances Act (CSA) itself or by DEA through scheduling actions; the enormous volume of international parcel traffic by mail and express consignment couriers; and the technological and logistical challenges of detection and inspection, make it extremely challenging for the U.S. Customs and Border Protection (CBP) to effectively address the threat at ports of entry and pave the way for non-cartel-affiliated individuals to undertake fentanyl trafficking. DEA is working with CBP to increase coordination on seized parcels.

Use of Freight Forwarders

Traffickers often use freight forwarders to ship fentanyl, fentanyl analogues, and other new psychoactive substances (NPS) from China. Several DEA investigations have revealed that the original supplier will provide the package to a freight forwarding company or individual, who transfers it to another freight forwarder, who then takes custody and presents the package to customs for export. The combination of a chain of freight forwarders and multiple transfers of custody make it difficult for law enforcement to track these packages. Often, the package will intentionally have missing, incomplete, and/or inaccurate information.

SIGNIFICANT ENFORCEMENT EFFORTS

Heroin Fentanyl Task Force

The DEA Special Operations Division (SOD) Heroin/Fentanyl Task Force (HFTF) working group consists of several agencies using a joint "whole-of-Government" approach to counter the fentanyl/opioid epidemic in the United States. The HFTF consists of personnel from DEA, U.S. Immigration and Customs Enforcement, Homeland Security Investigations (HSI) and CBP; supplemented by the Federal Bureau of Investigation and the U.S. Postal Inspection Service. HFTF utilizes every resource available, including support from the Department of Justice's Organized Crime Drug Enforcement Task Forces (OCDETF), OCDETF Fusion Center (OFC), and the Criminal Division, the Department of Defense (DOD), the intelligence com-

munity (IC), and other Government entities, and provides field offices (all agencies) with valuable support in their respective investigations.

The HFTF mission aims to:

- Identify, target, and dismantle command-and-control networks of national and international fentanyl and NPS trafficking organizations.
- Provide case coordination and de-confliction on all domestic and foreign investigations to ensure that multi-jurisdictional, multi-national, and multi-agency investigations and prosecutions have the greatest impact on targeted organizations.
- Provide direct and dynamic operational and investigative support for domestic and foreign field offices for all agencies.
- Identify new foreign and domestic trafficking, manufacturing, importation, production, and financial trends utilized by criminal enterprises.
- Analyze raw intelligence and documented evidence from multiple resources to develop actionable leads on viable target(s) involved in possible illicit pill production and/or distribution networks.
- Educate overall awareness, handling, trafficking trends, investigative techniques, and safety to domestic and foreign field offices for all law enforcement, DOD, IC, and Governmental agencies.
- Facilitate, coordinate, and educate judicial districts during prosecutions of fentanyl and other NPS-related cases.

Close interagency cooperation via the HFTF has led to several large enforcement actions, including the first-ever indictment, in two separate OCDETF cases, of two Chinese nationals responsible for the manufacturing and distribution of illicit fentanyl in the United States in October 2017. On October 17, the deputy attorney general and the DEA acting administrator announced the indictments of the Chinese nationals, who were the first manufacturers and distributors of fentanyl and other opiate substances to be designated as CPOTs. CPOT designations are of those who have "command-and-control" elements of the most prolific international drug trafficking and money laundering organizations operating in the world.

In addition, SOD's HFTF played an integral role in the July 2017 seizure and shutting down of the largest criminal marketplace on the internet, AlphaBay. As outlined by the attorney general and the DEA acting principal deputy administrator, AlphaBay operated for over 2 years on the dark web and was used to sell deadly illegal drugs, stolen and fraudulent identification documents and access devices, counterfeit goods, malware and other computer hacking tools, firearms, and toxic chemicals throughout the world. The international operation to seize AlphaBay's infrastructure was led by the United States and involved cooperation and efforts by law enforcement authorities in Thailand, the Netherlands, Lithuania, Canada, the United Kingdom, and France, as well as the European law enforcement agency Europol. Multiple interagency OCDETF investigations into AlphaBay revealed that numerous vendors, including many in China, sold illicit fentanyl and heroin on the site, and that there have been a substantial number of overdose deaths across the country attributed to such purchases.

Cooperation with Mexico

DEA's presence in Mexico represents our largest international footprint. The ability to have DEA special agents assigned to 11 different offices throughout Mexico is a reflection of the level of cooperation that we continue to enjoy with our Mexican counterparts. DEA supports bi-lateral investigations with the government of Mexico by providing information and intelligence to develop investigations that target leaders of TCOs throughout Mexico. The United States and Mexico have established a strong and successful security partnership in the last decade and, to that end, the U.S. Government stands ready to work with our Mexican partners to provide any assistance, as requested, to build upon these successes.

DEA Phoenix Field Division Response

DEA's Phoenix Field Division response has been multi-layered and comprehensive. No group in American law enforcement knows the Sinaloa Cartel and their operations better than DEA in Arizona, and our strategy was developed based on this long-term knowledge of how this organization operates.

The first pillar of the strategy involved increasing our focus on the command-and-control cells operating in Phoenix and Tucson. These cells are often difficult to penetrate and require lengthy, complex investigations targeting communication facilities and cartel members who direct operations throughout the United States and coordinate with high-level cartel leadership in Mexico. Working with our State, local, Tribal, and Federal partners, we have increased these complex conspiracy investigations targeting opiate trafficking by more than 60 percent over the last 3 years, resulting

in the arrest of hundreds of high-level traffickers, the seizure of thousands of pounds of heroin and fentanyl, and the disruption and dismantlement of many of these cells.

The second pillar of the strategy is enhancing DEA's ability to directly support Arizona State and local law enforcement efforts targeting overdose deaths and community impact. In 2016, the DEA Phoenix Field Division created the Heroin Enforcement Action Team (HEAT) in response to the growing opioid epidemic in Arizona. HEAT is an intelligence-driven enforcement approach partnered with our law enforcement, first responders, community outreach programs, and State health officials. DEA built a relationship with the Maricopa County Office of the Medical Examiner to receive nearly real-time investigative reports, leads, and statistics—information previously collected, but rarely utilized. This information led HEAT intelligence analysts to review overdose cases and then disseminate leads based on objective enforcement criteria. Further, the HEAT program also conducted overdose investigation training for our Task Force Officers (TFOs) and their local departments, then used these TFOs as "force multipliers"—conduits for both potential cases and evidence collection. For the first time in the Phoenix Division's history, DEA investigators responded directly to heroin and fentanyl overdose scenes in order to identify the source of supply. To date, DEA investigations in Arizona have resulted in the Federal indictment of three subjects for Distribution of a Controlled Substance Resulting in Death and Serious Bodily Injury 21 USC §1A 841(a)(1) and 841(b)(1)(C), and one plea to a State negligent homicide charge (ARS 13–1102) in Pima County.

In addition to the HEAT, DEA in Arizona hosts two Tactical Diversion Squads (TDS) in Phoenix and Tucson. TDS 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 toward investigating, disrupting, and dismantling those individuals or organizations involved in diversion schemes (e.g., "doctor shoppers," prescription forgery rings, and DEA registrants who knowingly divert controlled substance pharmaceuticals). Between March 2011 and present, DEA increased the number of operational tactical diversion squads (TDSs) from 37 to 77. In addition, DEA established two mobile TDS that can deploy quickly to "hot spots" around the country in furtherance of the Diversion Control Division's mission. Last year, the Phoenix TDS shut down two pharmacies and arrested a pharmacist engaged in the distribution of controlled substances,[23] and the Tucson TDS, in partnership with the Arizona Attorney General's Office, recently indicted a Tucson doctor on 26 State charges for unlawfully prescribing opioids.[24]

Community Outreach

The final pillar of DEA's strategy in Arizona involves a robust and comprehensive public awareness and education campaign. DEA and the Southwest Border High Intensity Drug Trafficking Area (HIDTA)—Arizona Region, joined efforts to organize the first Arizona Opioid Summit: Turning the Tide in January 2017, followed by a second summit in February 2018. The summits promoted the communication between traditionally isolated professions and furthered the collaboration between law enforcement, treatment, and prevention specialists. This past February, DEA and HIDTA partnered with the Institute for the Advancement of Behavioral Healthcare, who provided their National expertise and sponsorship of an additional 2 days of educational courses for medical professionals following the second summit. Over 400 law enforcement representatives, treatment and prevention specialists, medical practitioners, and community advocates attended this year's event. Additionally, the Phoenix Field Division has issued three alerts to the media and the public regarding new trends observed by DEA in Arizona,[25] including warnings of the first overdose fatalities attributed to the synthetic opioid U–47700, the prevalence of overdoses attributed to blue fentanyl pills, and the first report of an overdose death attributed to the powerful opioid carfetanil. These alerts were significant in fostering communication with the community as citizens themselves observe and subsequently report information to DEA's Tip Line. Furthermore, DEA routinely engages with the media in an effort to continue educating the public about the opioid crisis and its impact on the State, as well as the Nation. DEA in Arizona has been featured in over 100 media broadcasts related to the opioid crisis, most notably, two 30-minute investiga-

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[23] *https://www.dea.gov/divisions/phx/2017/phx070717.shtml.*

[24] *https://www.dea.gov/divisions/phx/2018/phx040518.shtml.*

[25] *https://www.dea.gov/divisions/phx/2017/phx011017.shtml, https://www.dea.gov/divisions/phx/2017/phx032117.shtml, https://www.dea.gov/divisions/phx/2018/phx041618.shtml.*

tive reports regarding heroin and diverted CPDs produced by Arizona State University's Walter Cronkite School of Journalism and Mass Communication. In a unique collaboration with local media entities, both reports, *Hooked: Tracking Heroin's Hold on Arizona* and *Hooked Rx: From Prescription to Addiction*, aired commercial-free and during prime time hours and reached over 2 million Arizonans.

CONCLUSION

Mexican TCOs remain the greatest criminal drug threat to the United States. These Mexican poly drug organizations traffic heroin, methamphetamine, fentanyl, cocaine, and marijuana throughout the United States, using established transportation routes and distribution networks. They control drug trafficking across the SWB and are moving to expand their share of U.S. illicit drug markets. Their influence up and down the supply chain, their ability to enter into new markets, and associations with gangs, are of particular concern for DEA. DEA will continue to address this threat domestically and abroad by attacking the crime and violence perpetrated by the Mexican-based TCOs, which have brought tremendous harm to our communities. In addition, DEA will extend its on-going public awareness campaign about the dangers of opioids and other drugs as part of its efforts to educate the community and other stakeholders who combat, treat, or are otherwise affected by this crisis every day. DEA will also work with our partners to address the significant challenge presented by new trend of deadly synthetics entering our country through the mail and express consignment systems.

Ms. MCSALLY. Thank you, Mr. Coleman.

The Chair now recognizes Mr. Roemer for 5 minutes to testify.

STATEMENT OF TIMOTHY ROEMER, DEPUTY DIRECTOR, DEPARTMENT OF HOMELAND SECURITY, STATE OF ARIZONA

Mr. ROEMER. Good morning, Chairwoman McSally, Ranking Member Grijalva, Congressman Gallego, Congresswoman Lesko, and Congressman Schweikert. Thank you for the opportunity to testify today on Arizona's efforts to combat the opioid epidemic and to combat illegal activity happening on our Southern Border.

Illegal activity perpetrated across the Southern Border of the United States infiltrates communities across Federal, State, local, and Tribal jurisdictions, making it absolutely necessary for law enforcement agencies at every level to work together in order to stop these threats.

Arizona's border county sheriffs, police chiefs, and their teams are on the front lines, protecting their communities every day. No one knows the effects of transnational crime on our citizens better than they do. They see the devastation of human trafficking on victims and their families. They see the destructive power that illegal drugs, overdoses, illegal weapons, and ammunition have on human lives, and they are dedicated to stopping it.

Formed in 2015, Arizona's Border Strike Force, led by the Arizona Department of Public Safety, is truly unique in the United States in that it harnesses the expertise and dedication of our local law enforcement and combines it with the power of the Federal Government to keep America safe. This team's intra-agency collaboration is unparalleled, and they have results to prove it.

No day or night is routine for this team, and I want to share a little more of what they have been interdicting on our behalf. A vehicle is stopped going north on I–17 and 5 pounds, or almost 225,000 hits of heroin, are found concealed in the spare tire. Yet another vehicle is stopped going westbound on I–10. Indicators of criminal activity prove true when 6 pounds of fentanyl are found wrapped in a gift bag.

To give you some perspective, a 2- to 3-milligram dose of fentanyl is known to be lethal. So in that one car driving down I–10 was enough to kill anywhere from 900,000 to over 1.3 million people. Those aren't even the large-scale operations like Operation Cascabel One and Two that resulted in the seizure of 131 pounds of meth, 12 pounds of cocaine, 618 pounds of marijuana, and 32 stolen vehicles, along with the arrest of 39 felons.

I want to emphasize that we can quantify results in a number of ways, but there is one metric we can't account for, and that is the number of lives that have been saved. Every human trafficker caught is one less wreaking havoc in the lives of their victims. Every dose of narcotics seized is one less destroying lives within our communities in Arizona.

We are saving lives because the Border Strike Force, and our Federal partners across two Presidential administrations, are taking the fight to heavily-armed drug cartels and those who would do us harm.

Arizona is also doing more, in real time, to prevent deaths from the scourge of opioid overdoses. Since Arizona's opioid emergency was declared in June 2017, we have provided over 6,000 kits or more than 12,000 doses of the overdose reversal drug Naloxone. This has been distributed to 63 law enforcement agencies across our State.

Nearly 1,000 law enforcement officers have been trained to recognize and treat an opioid overdose. These officers have administered Naloxone to 364 individuals, all but 9 of whom survived the immediate out-of-hospital event. Also since June, approximately 84 percent of the suspected non-fatal overdoses received Naloxone prehospital from EMS, law enforcement, or community members.

In closing, I want to say thank you once again to our Federal partners and everyone at the State, local, and Federal levels who support our efforts. I am confident that as our partnerships continue to grow in the form of information sharing, manpower, and monetary support, more lives will be saved, and we are grateful for that.

Thank you again for affording me the opportunity to testify this morning.

[The prepared statement of Mr. Roemer follows:]

PREPARED STATEMENT OF TIMOTHY ROEMER

MAY 30, 2018

Chairwoman McSally, Congressman Grijalva, distinguished Members of the subcommittee, and other Members in attendance, good morning and thank you for giving me the opportunity to testify on Arizona's efforts to combat the opioid crisis and criminal activity across our Southern Border.

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Thank you again for affording me the opportunity to testify this morning.

Ms. MCSALLY. Thank you, Mr. Roemer.

I now recognize myself for 5 minutes for questions.

Director Ramirez, the INTERDICT Act came out of our committee and was signed into law in January, which provided CBP $9 million to procure new opioid and other illicit substance screening devices, lab equipment, facilities, personnel, for all operational hours to expedite the testing of suspected opioids seized at the border and ports of entry.

Have you seen any of that flow into Arizona yet and making an impact at our ports of entry here?

Mr. RAMIREZ. Yes, ma'am, Chairwoman McSally.

Ms. MCSALLY. Can you just speak up?

Mr. RAMIREZ. For some reason this mic really wants to be very close to me.

We have. We have in a couple of areas. One of the biggest concerns we have, as you know, with fentanyl, as deadly as it is, is to ensure that as we dismantle vehicles and get the narcotics and we test them, that we do not contaminate any of our officers or the traveling public.

The technology that we are using, now thanks to the support of Congress, is our testing equipment, which is basically laser-based. Instead of having to take the narcotics and put it into a little pouch, you have the Gemini system which will read it, and we also have the glove boxes, which is a sealed compartment where you put the narcotics in, and then you put your hand in through gloves. It is completely sealed, and you test the narcotics. That, along with X-ray equipment, which is always welcome at the ports of entry, has been a great help.

Ms. MCSALLY. Great. Thank you.

This whole panel is about the supply, the easy supply that is out there for people to become addicted. Our next panel will be talking more about a whole-of-society approach to address some of the other root issues. But as we are looking to crack down on the supply, is it fair to characterize it as efforts have been made to crack down on the over-prescription and the pill mills and those types of things?

You have people who are addicted that are now going on to the illicit market because it is cheaper for them to get the product they need to feed their addiction, and that is where the dangers are increased because it can be laced with higher doses than expected, or other drugs, and people are overdosing and dying because they are being driven to the illicit market. Is that a fair characterization of what has happened and our level of awareness has gone up and how the dangers are increasing? If anybody wants to answer.

Mr. ROEMER. I believe so, if I may, Chairwoman. Four out of every five new heroin users start addicted to a painkiller, a prescription painkiller. So, as we have seen, as the Governor's testimony and all the great efforts of the State of Arizona, Dr. Cara Christ leading the Department of Health Services, as we have seen those statistics plummet of the number of opioids prescribed, that is going to make a huge dent in those new heroin users.

Ms. MCSALLY. Yes. Does anybody else want to comment on that?

Mr. COLEMAN. I think you hit it right on the head. The reality is that as we have seen our prescription drug epidemic increase, the Mexican cartels, as they always do, have taken advantage of the fact that we have so many. What has happened is that the increased heroin has created more competition for them, which has led to the increased production and distribution of fentanyl to make a stronger product to compete against each other to make sure they keep those repeat customers.

Ms. MCSALLY. OK, thanks.

So, we hear the number often that 90 percent of drugs that come over the border come through the ports of entry. When we are talking specifically about opioids, heroin, fentanyl, like everything that is related to this crisis, I don't know who can answer this, but do we have a percentage or understanding of what is coming through the ports of entry and what is coming through the mail from China?

Mr. COLEMAN. A difficult question to answer. The answer is if I knew where all of it was coming from, I would seize all of it.

Ms. MCSALLY. From what we know, just what we know.

Mr. COLEMAN. What we know is that the reality is that most of our large shipments of hard drugs are coming across the border.

We do see a significant portion coming through the mail of the smaller quantities, especially when it comes to fentanyl. So I don't know if there is a percentage we could put on it. Ninety percent probably seems a little bit high, but there is a very significant portion of it——

Ms. MCSALLY. But of that coming across the border, what number is coming through the ports of entry versus——

Mr. COLEMAN. For the hard drugs, it is probably 90 percent, at least. But marijuana and softer drugs come through—they walk across.

Ms. MCSALLY. So the reality is, obviously, because it is still so cheap on the streets, that a lot is getting through that we are not detecting. What else can we do in order to be able to detect it? We have some additional non-intrusive inspection capabilities. Is there anything else, Mr. Ramirez, that we can do? Because we are missing a lot of it, not related to the professionalism of your teams here. It is just very difficult to detect and intercept. So what else can be done?

Mr. RAMIREZ. I thank the continued support we have seen from Congress. When it comes to staffing, thank you for your support with the VRA. Staffing is a huge part of it, infrastructure and technology. So the continued support in those areas will absolutely help us dramatically in our efforts at the ports of entry.

Ms. MCSALLY. OK, great. I am going to yield back my 2 seconds.

The Chair now recognizes the Ranking Member, Acting Ranking Member, Mr. Grijalva, for 5 minutes.

Mr. GRIJALVA. Thank you very much, Madam Chair.

Mr. Ramirez, following up on the Chair's question—if I may, Madam Chair, if there is no objection, enter into the record a statement by Mr. Anthony Reardon, National President, National Treasury Employees Union, on the topic of this hearing.

Ms. MCSALLY. Without objection.

Mr. GRIJALVA. Thank you very much.

[The information follows:]

STATEMENT OF ANTHONY M. REARDON, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION

MAY 30, 2018

Chairman McSally, Ranking Member Vela, distinguished Members of the subcommittee, thank you for the opportunity to provide this testimony on the role of Customs and Border Protection (CBP) in addressing the Nation's opioid crisis. As president ofthe National Treasury Employees Union (NTEU), I have the honor of leading a union that represents over 25,000 CBP officers, agriculture specialists, and trade enforcement specialists stationed at 328 land, sea, and air ports of entry across the United States and 16 PreClearance stations.

Any discussion of the opioid crisis and the resources needed to stop the movement of opioids across the border must include the role of CBP officers at the ports of entry and the need to hire new CBP Office of Field Operations (OFO) personnel. Between 2013 and 2017, approximately 25,405 pounds, or 88 percent, of all international arrivals of opioids, were seized by CBP officers at the ports of entry.

CBP OFO is the largest component of CBP responsible for border security—including anti-terrorism, immigration, anti-smuggling, trade compliance, and agriculture protection—while simultaneously facilitating lawful trade and travel at U.S. ports ofentry that are critical to our Nation's economy. CBP OFO has a current need to hire 2,516 additional CBP officers and 721 agriculture specialists to achieve the staffing target as stipulated in CBP's own fiscal year 2018 Workload Staff Model (WSM) and Agriculture Resource Allocation Model (AgRAM.) According to CBP's

Congressional Affairs Office, as of May 4, 2018, CBP OFO has 23,147 CBP officers on-board at the ports of entry—1,328 short of the authorized staffing level of 24,475.

Trade and travel volume continue to increase every year, but CBP OFO staffing is not keeping pace with this increase. New and expanded Federal inspection facilities are being built at the air, sea, and land ports, yet CBP OFO staffing is not expanding. For example, in June, a new Federal inspection terminal will open at the San Diego Airport. Inspection volume will increase from 300 air passengers an hour to 1,000 air passengers an hour. Currently, there are a total of 53 front-line officers split between the airport and seaport. CBP needs to hire and assign an additional 38 officers to the airport alone to staff this new inspection facility. At the San Ysidro land port, 12 new pedestrian lanes and 8 new vehicle lanes come on line in June. There are no new CBP officers assigned to this port and beginning on April 1, 2018, 150 CBP officers have been sent from other short-staffed ports to the seriously short-staffed ports of Nogales and San Ysidro for 90-day temporary duty assignments.

To address CBP OFO staffing shortages, and to address the expected, ever-increasing volume of trade through the ports of entry in the future, Ranking Member Vela and others recently introduced H.R. 4940, the Border and Port Security Act, stand-alone, bipartisan legislation that would authorize the hiring of 500 additional CBP officers, 100 CBP agriculture specialists, and additional OFO trade operations staff annually until the staffing gaps in CBP's various Workload Staffing Models are met. NTEU strongly supports this CBP officer and agriculture specialist—only staffing authorization bill and urges every Member of Congress to support this bill.

NTEU also asks Committee Members to request from the House Appropriations Committee up to $100 million in fiscal year 2019 direct appropriations for the hiring of 500 CBP officers, 100 CBP agriculture specialists, and additional needed non-uniformed Trade Operations and support staff.

The President's fiscal year 2019 budget request does support the hiring of new CBP officers to meet the current staffing need of 2,516, but seeks to fund these new positions by increasing user fees. The President's budget proposal only provides appropriated funding to hire 60 new CBP officer positions at the National Targeting Center. The President's request seeks no appropriated funding to address the current CBP officer staffing shortage of 2,516 additional CBP officers as stipulated by CBP's own fiscal year WSM or to fund the additional 721 CBP agriculture specialists as stipulated by CBP's own fiscal year 2018 AgRAM.

User Fees.—As in the past, the administration's budget proposes significant realignment of user fees collected by CBP. Currently, 33 percent of a CBP officer's compensation is funded with a combination of user fees, reimbursable service agreements, and trust funds. The fiscal year 2019 budget proposes to reduce OFO appropriated funding by realigning and redirecting user fees, including redirecting the Electronic System for Travel Authorization (ESTA) fee that would require a statutory change. The fiscal year 2019 budget proposal would redirect approximately $160 million in ESTA fees from Brand USA to CBP. Rather than redirecting the ESTA fees to fund the additional 2,516 CBP officer new hires needed to fully staff CBP officer positions in fiscal year 2019 and beyond, as stipulated by CBP's WSM, the budget would in fact reduce CBP's appropriated funding by $160 million. Therefore, while the budget proposes to increase the number of CBP officer positions funded by ESTA user fees by 1,093, it decreases appropriated funding by $160 million, and reduces the number of CBP officer positions funded by appropriations by 1,093 positions.

Once again, the President's budget includes CBP officer staffing numbers that are dependent on Congress first enacting changes to statutes that determine the amounts and disbursement of these user fee collections. To accomplish the ESTA fee change in the President's budget, Congress must amend the Travel Promotion Act of 2009 (Pub. L. 111–145). The President's request also proposes fee increases to the Immigration and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) user fees, not a direct up-front appropriation, to fund CBP officer new hires as stipulated by the WSM. However, Immigration and COBRA user fees cannot be increased without Congress first enacting legislation. A proposal to increase user fees has been part of the administration's annual budget submission since fiscal year 2014 to fund the hiring of new CBP officers. These user fee increase proposals are again in the fiscal year 2019 budget request, even though the committees with jurisdiction have never shown any interest or even held a hearing to discuss this long-standing legislative proposal, and the administration has not pressed upon these committee chairs to do so.

Opioid Interdiction.—CBP OFO is the premier DHS component tasked with stemming the Nation's opioid epidemic—a crisis that is getting worse. In a report released on May 10, 2019, by the Senate Homeland Security and Governmental Af-

fairs Committee Minority titled "Combatting the Opioid Epidemic: Intercepting Illicit Opioids at Ports of Entry", CBP officers at the ports of entry were found to "play a key role in stopping opioids and that CBP has significant shortages of Port Officers that may be compromising efforts to seize additional opioids before they can reach U.S. communities."

The smuggling of fentanyl and other opioids has increased markedly. According to the report, "between 2013 and 2017, approximately 25,405 pounds, or 88 percent of all opioids seized by CBP, were seized at ports of entry. The amount of fentanyl seized at the ports of entry increased by 159 percent from 459 pounds in 2016 to 1,189 pounds in 2017."

The scourge of synthetic opioid addiction is felt in every State and is a threat to the Nation's economic security and well-being. The majority of fentanyl is manufactured in other countries such as China, and is smuggled primarily through the ports of entry along the Southwest Border and through international mail and express consignment carrier facilities (e.g. FedEx and UPS).

According to CBP, on March 24, 2018, CBP officers arrested an individual at Arizona's San Luis port of entry after discovering 3.5 pounds of methamphetamine, worth nearly $11,000, wrapped around his torso. Also, at San Luis, on April 27, 2018, a CBP canine team alerted CBP officers to a vehicle that was found to have concealed within its quarter panels more than 70 pounds of methamphetamine worth over $210,000.

As the Senate report states, CBP officers are, "in the majority of cases, the last line of defense in preventing illicit opioids from entering the United States . . . CBP's current shortage of over 4,000 port officers is directly influencing operations and staffing these positions could increase CBP's ability to interdict opioids."

Also, according to CBP, over the last 3 years, there were 181 CBP employees assigned to the five Postal Service International Service Centers and 208 CBP employees assigned to the Private Express Carrier Facilities.

According to the report, on average, CBP officers only inspect 100 of the 1.3 million in-bound international packages that arrive daily by international mail. In 2016, 65 million packages arrive via express carriers, which are required by law to provide advanced electronic data. However, this data can be incomplete. "For example, from 2014 and 2016, CBP issued over 5,000 penalties for incomplete manifest information and assessed over $26 million in fines. However, express shippers successfully negotiated penalties down to just over $4 million."

In the past year, the FedEx hub in Memphis processed 38 million imports and 48 million exports—equaling 86 million in total package volume. There are approximately 24 CBP officers in total screening all 86 million shipments, and on average, about 15 CBP officers are working the main overnight FedEx "sort" shift. Considering the volume at the FedEx hub, NTEU has been told that the port requires a minimum of 60 CBP officers to facilitate the flow of legitimate freight and ensure successful interdiction of these synthetic chemicals. NTEU's CBP OFO appropriation request supports both the critical need at the air, sea, and land ports of entry, but also at international postal and express consignment hubs.

Last, the Nation's busiest land port of entry San Diego, along with the Tucson area land ports, account for "57 percent of all opioids seized by ports of entry, including 75 percent of all fentanyl and 61 percent of all heroin seized." These two land ports are also the most critically understaffed. According to CBP, "these long-term staffing shortfalls continue to stretch the limits of operational, enforcement and training capabilities at the ports of entry." To address these shortfalls, CBP solicits non-supervisory officers to serve in Temporary Duty (TDY) assignments. Since November 1, 2015 between 80 and 200 CBP officers per quarter have been TDYed to the San Diego and Tucson land ports. The continuing lack of CBP officer staffing at these ports of entry results in forced overtime shifts, multiple deployments away from home, and low morale.

Agriculture Specialist Staffing.—Despite CBP's release of its risk-based AgRAM that documents an on-going shortage of CBP agriculture specialists—by 721—at the ports of entry, the budget request includes no direct appropriation to hire these critical positions needed to fulfill CBP's agriculture quarantine inspection (AQI) mission of pest exclusion and safeguarding U.S. agriculture and natural resources from the risks associated with the entry, establishment, or spread of animal, plant pests, and pathogens. NTEU's appropriations request includes a direct appropriation to begin to hire the 721 agriculture specialists as stipulated in their fiscal year 2018 AgRAM.

CBP Trade Operations Staffing.—CBP has a dual mission of safeguarding our Nation's borders and ports as well as regulating and facilitating international trade. CBP employees at the ports of entry are the second-largest source of revenue collection for the U.S. Government. In 2017, CBP processed more than $2 trillion in im-

ports and collected approximately $40 billion in duties, taxes, and other fees. Since CBP was established in March 2003, however, there has been no increase in non-uniformed CBP trade enforcement and compliance personnel even though inbound trade volume grew by more than 24 percent between fiscal year 2010 and fiscal year 2014. Additionally, CBP trade operations staffing has fallen below the statutory floor set forth in the Homeland Security Act of 2002 and stipulated in the fiscal year 2017 CBP Resource Optimization Model for Trade Positions. NTEU strongly supports the funding through direct appropriations of 140 additional positions at the CBP Office ofTrade to support implementation of the Trade Enhancement and Facilitation Act (Pub. L. 114–125) requirements.

Hiring Contract.—A funding proposal of concern to NTEU is a $297 million contract that CBP recently awarded to Accenture Federal Services "to manage the full life cycle of the hiring process from job posting to processing" of 7,500 CBP Border Patrol, Air and Marine, and OFO new hires. NTEU has seen reports that the 5-year contract cost is approximately $39,600 per hire—nearly the same as the starting salary of a CBP officer. NTEU strongly believes that these Federal funds would be better spent actually hiring new CBP employees using CBP's in-house human resources department rather than in contracting out to a private-sector consultant "to augment our internal hiring capabilities."

The best recruiters are likely current CBP officers. Unfortunately, morale continues to suffer because of staffing shortages and a threatened pay freeze, and the administration's proposed cuts to retirement, health care, and workers' compensation programs. In addition to being overworked due to excessive overtime requirements, temporary duty assignments are a major drag on employees, especially those with families. Based on their experiences, many officers are reluctant to encourage their family members or friends to seek employment with CBP. I have suggested to CBP leadership that they look at why this is the case.

NTEU strongly believes that addressing OFO hiring shortages by funding needed new CBP officer and agriculture specialist to fill the fiscal year staffing gap will do more to improve morale and encourage peer-to-peer recruitment than funding a private contractor to help recruit and hire new CBP employees.

Increasing CBP officer staffing at the ports-of-entry is an economic driver for the U.S. economy. According to the Joint Economic Committee (JEC), "every day 1.1 million people and $5.9 billion in goods legally enter and exit through the ports of entry" and finds that border delays cost the U.S. economy upwards of $5 billion each year. CBP estimates that the annual hiring of an additional 500 CBP officers at the ports of entry would increase yearly economic activity by $1 billion and result in an additional 16,600 jobs per year to the U.S. economy.

Thank you for the opportunity to submit this statement on the CBP OFO resources needed to secure and protect the United States on behalf of the men and women represented by NTEU at the Nation's ports of entry. On behalf of our CBP members, NTEU requests are for Homeland Security Committee Members to cosponsor the bipartisan CBP OFO staffing authorization bill, H.R. 4940, and to ask the House Appropriations Committee for $100 million in direct appropriated funding for new CBP officers, agriculture specialists, and support staff to build on the CBP OFO staffing advances made in the fiscal year 2018 Omnibus measure.

Mr. GRIJALVA. To address the CBP staffing shortages, and to address the ever-increasing volume of activity at the ports of entry, that involves also the economics of it, as you have explained to me in terms of trade, import/export at the ports of entry, not just now but in the future. Ranking Member Vela from this committee introduced H.R. 4940, a bipartisan bill, the Border and Port Security Act, that would authorize the hiring of 500 additional CBP Customs officers, 100 CBP agricultural specialists, and an additional Trade Operations staff annually until you begin to close the staffing gaps at the ports of entry.

Your reaction to that piece of legislation? Do you see that as part of the deterrence that we are talking about today and the seizures that we are talking about today?

Mr. RAMIREZ. Absolutely. That is welcome news, Congressman Grijalva. When we talk about our complex jobs at the ports of entry, as you know, it is a balance between facilitating legitimate

trade and travel and interdicting bad people and bad things. So our job is to encourage travel and trade, not discourage it.

So obviously, staffing is a big part of it. We have implemented a huge recruitment effort in our agency where basically every recruiter Nation-wide at this point is recruiting for Arizona. Having those extra bodies allows us not just to open additional lanes but to provide better service to the traveling public and the trade community, and again operate more of our canines, our X-rays, and have a stronger enforcement posture at our ports of entry. So, thank you very much.

Mr. GRIJALVA. Thank you.

Mr. Coleman, if I may, the process of coordination of all these activities, interagency coordination, across jurisdictions coordination, and with stakeholders in various communities and others, I know it is rare but there are some turf issues sometimes. It certainly doesn't happen with Members of Congress——

[Laughter.]

Mr. GRIJALVA. But I am sure it is the same experience that you have.

[Laughter.]

Mr. COLEMAN. Welcome to my district.

Mr. GRIJALVA. Tell me a little bit about the DEA, the principal agency, but also Homeland Security now having broad authority over the same subject. Tell me about that interagency issue.

Mr. COLEMAN. I think that, having been a 30-year law enforcement officer, I can tell you that—and I have worked all over the country and the world—I think that the relationships between Arizona law enforcement agencies at the Federal, State, and local level is unprecedented in my career. While we occasionally get into spats over issues, there is nothing that we haven't been able to solve in the time I have been here, which is 11 years now. Scott's people are integrated in my offices, and my people are integrated in his offices. We work very closely together. We are partners on many task force groups. I have over 80 State and local officers assigned to my task forces. He probably has a similar number. So our integration is complete as much as we can be in the State.

Mr. GRIJALVA. Thank you.

My last point, Mr. Roemer, you mentioned all those other things. You mentioned quickly about weapons. Seventy percent, based on statistics from 2009 to 2014, of weapons seized across the border, in Mexico primarily, came from the United States. That is the origin. It is legal, weapons possession in Mexico. It is legal to have them, and they are primarily in the hands of cartels, and they have savaged that country as well.

So what do you see in terms of what we are able to do in terms of what is going from here to there?

Mr. ROEMER. Sure. Ranking Member Grijalva, just the Border Strike Force—it is a huge concern for us from a public safety perspective. Just the Border Strike Force alone——

Mr. GRIJALVA. But statistically, you mentioned tonnage and all that. Have you re-arrested people?

Mr. ROEMER. Absolutely. So, 280 firearms have been seized just by the Border Strike Force during Border Strike Force operations. But staying up-to-date on a daily basis on what Mr. Ramirez and

all of CBP is doing and the success they are having, they are interdicting more weapons going south-bound across the border. I don't have the exact statistics for you, but I will tell you that I have been very pleasantly surprised at the number of success stories coming out of CBP on those weapons going south-bound.

Mr. GRIJALVA. I yield back, Chairwoman.

Ms. MCSALLY. The Chair will now recognize Mr. Schweikert for 5 minutes.

Mr. SCHWEIKERT. Thank you, Madam Chairwoman.

That is an interesting point. The leaky border basically devastates people on both sides, and there becomes the discussion of what do we do to lock it down.

Forgive me, this may be more for Mr. Brown than Mr. Coleman, a quick thought experiment. Many have been working on pieces of legislation. We are blessed that they look like they are going to move, prior authorization for opioids, some changes within the way opioids are prescribed, the ability for pharmacies, the data to see it.

What happens if we are successful, that the prescription level of opioids crashes? Do the bad actors come and say, well, you are cutting our future profits because the migration we were hearing before of medical opioids that in the future potentially becoming a customer for heroin, eventually a customer maybe for fentanyl, do the bad actors try to find another way to continue the level of usage and devastation in our society?

Mr. ROEMER. I think over the short term that will happen. I think there is no question that we have to lower the amount of these prescriptions that we are writing to get hold of the actual number of addicted that we have here. I do think that the cartels will make moves to try to keep that addicted population addicted so they can continue.

Mr. SCHWEIKERT. Do they go out and try to find new customers?

Mr. ROEMER. That is what they do. They recruit customers, and they also introduce new products into the system, fentanyl and its analogues and things like that, to get people more and more hooked.

Mr. SCHWEIKERT. OK, that is partially where I wanted to go.

Mr. Brown.

Mr. BROWN. I would echo what Doug said, and I would add I think one of the things we are seeing commonly is they are pressing fentanyl into a pill form.

Mr. SCHWEIKERT. As you know, yesterday there was a large bust of what we thought was a prescription. It turns out it was a derivative of a fentanyl product.

Mr. BROWN. So I think that is a way of kind of marketing it to those people that started out with a legitimate opioid addiction. I think the reality is there are going to be some people that, when they recognize that I am going to a wholly illegal source to get my drugs, that will scare a couple of people away and scare them into the treatment that they need. To save those couple of lives, I would agree with Doug that we need to work——

Mr. SCHWEIKERT. It is an interesting thought experiment that will our success on one side, because there we can treat it as a

medical crisis, ends up moving that population into almost a criminal, much more difficult to identify populations to help.

Mr. Ramirez, help me understand. I sat through a security briefing almost a year ago. It was a very small one, a little geeky. We actually did the chemical compounds that are in fentanyl, and I think they were using some other derivatives of fentanyl, and just the stunning addictive, poisonous—how small it was.

How do you capture—how do you find it when something the size of your pinky is the death of all of us in this room?

Mr. RAMIREZ. It is a very scary proposition, Congressman. At the ports of entry, what we are encountering is large quantities. It is amazing when I look, as I said, 30 years in. I remember when I started with Customs in El Paso, if you caught 1 kilo of heroin back then, you were the man for a year.

Today, when we see 60 or 70 pounds, and what they are coming in, the packages are coming with multiple pills in the package——

Mr. SCHWEIKERT. My concern, though—and this may be more of a question for a chemist. Heroin, fentanyl, for the same market value, or for the same addictive quality, what is my volume difference?

Mr. RAMIREZ. We don't know that until we send it to the labs, including the DEA labs, and have them test it. I believe that would be a question more suited for Mr. Coleman.

Mr. SCHWEIKERT. Mr. Coleman.

Mr. COLEMAN. Fentanyl is obviously much stronger than heroin, and what we see is the profit margin on a kilogram of fentanyl, $30,000 for a kilo, $1.5 million is the profit you can make off of that.

Mr. SCHWEIKERT. So you strain to see a movement away from heroin products to——

Mr. COLEMAN. Unfortunately, we see both coming in. We have seen massive increases in the fentanyl and massive increases in the heroin to feed that addicted population.

Mr. SCHWEIKERT. My understanding is there are some new chemical derivatives of fentanyl that are even more dangerous than——

Mr. COLEMAN. Yes. When you talk about fentanyl, it is a synthetic opioid, so with just very small chemical changes you can create different drugs—carfentanyl, U47–700. Some of those drugs are hundreds of times more powerful than fentanyl.

Mr. SCHWEIKERT. The carfentanyl was fascinating chemically.

Madam Chairman, forgive me, I know I am over time. But for all of us on the panel, it is worth a bit of a thought experiment—and I don't want to speak out of what was given to us in the SCIF, but if that type of product ended up in something we are all publicly consuming, could you imagine the brutality that comes with that?

Ms. MCSALLY. The gentleman's time has expired.

Ms. Sinema had to go, so the Chair now recognizes Mr. Gallego for 5 minutes.

Mr. GALLEGO. Thank you, gentlemen.

Director Ramirez, I am very lucky to serve on the Armed Services Committee, and in that we have to make decisions between whether we are going to buy tanks, aircraft carriers, a whole lot

of things. It ranges from bullets to bombs, and I have to make those decisions every year through the National Defense Authorization Act.

When it comes to fighting the opioid epidemic, we don't have an unlimited amount of resources either for this, right? If you haven't heard, we are in debt. We are going even more into debt because of this latest tax plan, and we will probably do that for the next 10 years.

If I had the opportunity to get you $25 billion and you had to choose between a wall or to put more men at Customs and the border, men and women, professionals at our Customs and ports of entry, where would you choose your resources to be in terms of trying to fight the opioid epidemic?

Mr. RAMIREZ. That is a little unfair.

Mr. GALLEGO. I know, that is why I asked it.

[Laughter.]

Mr. GALLEGO. If it was fair, I wouldn't ask it.

Mr. RAMIREZ. Because you are not going to find a port director who is going to say that he cannot do without more men or women.

Mr. GALLEGO. OK. I don't want to get you into trouble, so we will stop there. I appreciate the honesty.

One of the other areas that Congresswoman McSally has talked about, Congresswoman Sinema has talked at great length about this also, is because of the understaffing at the ports of entry, we are actually essentially using temporary personnel right now to fill those gaps. In terms of operational outcomes, what is that causing in terms of the consequences of that on an everyday basis, or just in terms of long-term sustainability?

Mr. RAMIREZ. Well, long term, with our new recruiting efforts and the fact that we finally have people in the pipeline both pre-academy and academy and post-academy, it looks like there is light at the end of the tunnel. Long term, it actually benefits the agency when you bring people from other ports of entry.

As you know, the Southwest Border is very unique when it comes to our jobs, very exciting and action-filled, very different from someone who sits in an airport or a Northern Border port. So when they have an opportunity to come and work side-by-side with the men and women assigned to the ports of Arizona, it is a learning experience which they take back to their ports of entry, and in turn it strengthens the operations at those ports of entry.

I hear it from port directors who are not happy about having to give up resources for a short time, but when those resources get back, they are very pleased with what they find.

Mr. GALLEGO. Then to dive a little deeper, in terms of what we are looking at in terms of shortages right now for permanent staff, how many would you say do we need to fill the gap, especially in the Tucson sector?

Mr. RAMIREZ. In the Tucson Field Office, I believe we are still a few hundred positions short. Like I said, we have had success in hiring, but with attrition, it is a couple of steps forward, one step back kind of thing. So we are still a few hundred overall short.

Mr. GALLEGO. Is the attrition because of Baby Boomers aging out, or just because people find that the strain of the job is just too much for their family, or just for personal income reasons?

Mr. RAMIREZ. No, it is really more that blood is thicker than water. A lot of folks, we hire them from other parts of the United States, and in time they want to get back to family. We have had some of our officers who have transferred to get closer to family who have since come back to help us out in temporary assignments, and they will tell you that they miss the camaraderie, they miss the esprit de corps at the Arizona ports of entry, and they actually miss living in Arizona. So most of it is people rotating out, trying to get closer to home and family.

Mr. GALLEGO. So, unfortunately, the cartels, they are very well-funded themselves. They are innovative. They have a product they need to sell, and they have a market that wants it. What are we doing in terms of technology to keep up with all the ways that they are trying to get their illicit drugs into this country, and is there more we can do along those lines to basically ratchet up our levels to make sure we are matching their levels?

Mr. RAMIREZ. You know, one of the best X-ray systems that we have right now, newly implemented, is the Z-Portal technology, which is actually a low-energy system where the travelers do not have to get out of their vehicles. You just drive right through. That is one of the best tools. We just finished installing the latest one in San Luis. We have one in Douglas.

Mr. GALLEGO. How many more of those do we need?

Mr. RAMIREZ. I would like to see one at every port of entry, and we are almost there, especially our larger ports of entry. We already have them in Douglas, Nogales, San Luis, and in Lucasville. So we are about there.

Mr. GALLEGO. Excellent.

Mr. RAMIREZ. But those have been a great addition to our enforcement posture.

Mr. GALLEGO. Thank you. I yield back.

Ms. MCSALLY. The gentleman yields back.

The Chair now recognizes Ms. Lesko for 5 minutes.

Ms. LESKO. Thank you, Madam Chair.

I want to say to the panel, thank you for your service to our country, and thank you to all the law enforcement that works to protect our communities and our country. I really appreciate it.

I think you testified—and this is to any of you—that most of the illicit opioids come through the ports of entry. From the data that I see here, it mostly is coming through the San Diego sector, it looks like. Correct me if I am wrong.

My question is if people are being inspected, if they know they are going through a port of entry and they know they are going to be inspected, why would they come through the ports of entry, and how do you know that there is not a bunch of drug traffickers coming through other parts of the border?

Mr. COLEMAN. From a DEA perspective I can tell you that the reality is that they certainly know that some of them are going to get taken off as they come across, but they will send multiple people through at a time. When CBP catches them, moves them away, then four others can sneak in behind them. So they use a variety of techniques. But they build into their business model the fact that they are going to lose a significant portion of them that come

across. So they flood us, essentially, with more people coming across than we can catch.

Ms. LESKO. Thank you for that answer. But my question is you testified—well, not you specifically, but that they strap it on their body and that type of thing. But how do you know that a bunch of people aren't coming through other areas of the border, not ports of entry, that have strapped-on illicit drugs because they are not going through a port of entry where there is going to be any type of inspection?

Mr. BROWN. Again, we have procedures made by Border Patrol that they really aren't encountering hard narcotics between the ports of entry. The reality is if you cross at a non-port of entry, if you are detected, you are going to be stopped, you are going to be apprehended, you are going to be searched.

If you are coming through a port of entry, you are blending in with a huge volume of traffic, of which we can only inspect a small portion of those vehicles and pedestrians, so it is playing the odds. Again, you are automatically doing something wrong and are going to be more heavily scrutinized if you are coming across between ports of entry.

Ms. LESKO. Thank you.

Madam Chair and anyone from the panel, I know that you may not know the exact answer to this, but for every amount of illicit drugs that you detect, how much do you think is undetected? It is hard to know, I know, but you probably have a guess.

Mr. COLEMAN. There is a significant portion that gets through, obviously. At DEA we work around the entire world, so we see the expansion of these drugs coming in and landing in other States, stuff that we know came through the port of entry. Our cases lead us from other parts of the country back to Arizona. So we know that there is a lot that gets through. I shudder to hazard a guess, but there is a significant amount that gets through all of us.

Ms. LESKO. Thank you.

I yield back my time.

Ms. MCSALLY. The gentlelady yields back.

I do want to note that the appropriations bill included $284 million for port and drug inspection technologies within CBP, and $71 million specifically for opioid detection. So hopefully we are seeing more flow to the different ports of entry, more technology flow to the ports of entry for that non-intrusive inspection.

We have a lot more to talk about, but we don't have a lot of time, so I just want to say thanks to our witnesses for all that you do in order to keep our communities safe, and everything that all of your members do every single day to keep us safe and to address this issue.

There is a lot more that we can do together to solve, so this is just really a platform for us, and we look forward to continuing to work with you moving forward to address this crisis.

I want to thank all the witnesses for their testimony and the Members for their questions. The Members of the committee may have some additional questions for the witnesses. We will ask you to respond to those in writing.

With that, I will dismiss this panel and request that the Clerk prepare the witness table for our third panel.

[Recess.]

Ms. MCSALLY. While the last panel was very much focused on the supply of these addictive opioids and other substances, this panel is going to be talking more about solutions within society, civic society, and all elements, what can we be doing to have early identification and prevention and treatment to provide wholeness for people who have struggled with addictions. So, I am really looking forward to the discussion on this panel.

I am pleased to welcome five distinguished witnesses for our third and final panel today. First is Dr. Cara Christ, who serves as director of Arizona Department of Health Services. She has worked for the agency for more than 9 years in multiple positions. In May 2015, Dr. Christ was appointed as director by Governor Doug Ducey.

The second witness is Dr. Glorinda Segay, who became the health director of Navajo Nation in July 2017. In this position she is responsible for overseeing the direction of 14 different programs which include direct patient care as well as the provision of Medicaid and Medicare for the Navajo people. Previously she provided psychotherapy and group therapy treatments, as well as working on suicide prevention.

Ms. Debbie Moak became the director of the Governor's Office of Youth, Faith, and Family in 2015. She served as director under Arizona Governor Ducey until June 2017. Previously she worked as an elementary school teacher for 10 years. In 1999 she co-founded notMYkid, an anti-substance abuse non-profit, with her husband. The non-profit aims to help young people make positive choices.

Mr. Jay Cory has served as the president and CEO of the Phoenix Rescue Mission since September 2011. Mr. Cory has over 25 years of senior leadership experience in religious-based rescue and recovery ministries, with a proven track record of success in building ministry and recovery programs.

Mr. Wayne Warner is a graduate of Teen Challenge, a faith-based program with practical solutions for men and women with life-controlling issues. I am very familiar with Teen Challenge. I was a former board member of Teen Challenge. Initially a skeptic, Wayne graduated in 2014 and is now a firm advocate for the program which helps people "become mentally sound, emotionally balanced, socially adjusted, physically well, spiritually alive, and employment ready."

The Chair now recognizes Dr. Christ to testify.

STATEMENT OF CARA M. CHRIST, M.D., DIRECTOR, DEPARTMENT OF HEALTH SERVICES, STATE OF ARIZONA

Dr. CHRIST. Chairwoman McSally and other Members in attendance, thank you for this opportunity to share our progress toward Arizona's public health emergency, the opioid epidemic.

The opioid crisis is different than other drug epidemics. While heroin and other illicit opioids present a problem in our communities, the start for many who develop opioid use disorder begins in a doctor's office in an attempt to relieve pain.

It wasn't until recently that medical professionals realized how dangerous these medications are. Merely taking them as directed for 6 days or more significantly increases your chance of depend-

ence. Four out of five new heroin users started as opioid medication users.

We knew to address this issue our response required a coordinated, multifaceted approach from all sectors, including public health and medical professionals, law enforcement, patients, and many others in our communities.

Last year my agency, the Arizona Department of Health Services, issued our report on opioid deaths, showing more than two Arizonans died each day in 2016 from these dangerous drugs. Upon release of that report, Governor Ducey took decisive action and declared a public health emergency, mobilizing resources and allowing us to collect real-time data. Within hours of the declaration, our Health Emergency Center began analyzing data, gathering partners, and identifying solutions.

The numbers reported are staggering. Since June 2017, over 1,200 suspected opioid deaths, 8,000 overdoses, and 760 babies with neonatal abstinence syndrome have been reported to the Department. After over 50 stakeholder meetings involving over 1,350 partners, the Department issued our Opioid Action Plan.

During the past year, Arizona has been implementing our plan and completing the activities Governor Ducey directed in the emergency declaration, and we have made great progress. The reporting and information-sharing requirements first established through the enhanced surveillance activity are now codified in rule. Almost 1,000 law enforcement officers State-wide have been trained to provide Naloxone, and to date we have provided over 6,100 Naloxone kits to over 63 law enforcement agencies throughout Arizona, allowing our officers to save lives by reversing overdoses in the field.

Our health care facilities now have rules for opioid prescribing and treatment, ensuring they have policies and procedures aimed at preventing opioid use disorder. We are also in the process of developing rules to regulate pain management clinics and end pill mills.

Our Arizona Opioid Prescribing Guidelines have been updated to incorporate the newest information from the Centers for Disease Control and Prevention, encourage a shift in pain care to avoid unnecessary exposure to opioids, and emphasize the use of non-stigmatizing language.

We have created a free, 24/7 State-wide consultation opioid assistance and referral line. This is for prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder.

One hundred percent of Arizona's health professional schools participated in the development of the Nation's first State-wide curriculum across all prescriber training programs for pain and addiction using a whole-person approach. Integration of this curriculum is said to begin during the 2018–19 school year.

We have also partnered with the Arizona Department of Corrections to pilot a program that provides free Naloxone for individuals at high risk of overdose who are released from our correctional facilities. Multiple State agencies, including AHCCCS, the State's Medicaid program, the Governor's Office of Youth, Faith, and Family, and the Arizona Board of Pharmacy have come together to increase access to peer support, enhance youth prevention programs,

and improve the Controlled Substances Prescription Monitoring Program.

However, one of the biggest successes is the unanimous bipartisan passage of the Comprehensive Arizona Opioid Epidemic Act that went into effect on April 26. The Act consists of a number of life-saving policy initiatives, including a $10 million investment to enhance access to treatment for uninsured or underinsured Arizonans, a Good Samaritan law to allow people to call 9–1–1 for a potential opioid overdose, requiring insurance companies to make one form of medication-assisted treatment available without a prior authorization, and limiting the first fill of an opioid prescription to 5 days for all opioid-naive patients while protecting chronic pain patients currently on these medications.

While this legislation just went into effect, we are already seeing improvements based on our comprehensive efforts. In addition to the statistics that Governor Ducey presented earlier, we have also seen a 50 percent decline in the number of high-dose prescriptions when you look at this since last April.

Though we have completed all of the directed activities and the emergency declaration has been terminated, we know that our work is just beginning. Arizona has an on-going commitment to continue to identify and implement new solutions to prevent future overdoses and deaths.

Thank you for allowing me to talk about our progress today.

[The prepared statement of Dr. Christ follows:]

PREPARED STATEMENT OF CARA M. CHRIST

MAY 30, 2018

The Arizona Department of Health Services (ADHS) released the 2016 Arizona Opioid Report on June 1, 2017. This report revealed that in 2016, 790 Arizonans died from opioid overdoses—more than 2 people per day. Arizona has experienced an alarming increase in opioid deaths of 74 percent since 2012. In the past decade, 5,932 Arizonans died from opioid-induced causes with death rates starting to rise in the late teens and peaking at ages 45–54. This data highlighted a need for action. On June 5, 2017, Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths in Arizona.

HEALTH EMERGENCY OPERATIONS CENTER

The ADHS team immediately sprang into action and activated the Health Emergency Operations Center (HEOC) within hours of the Governor's emergency declaration. More than 75 agency staff across ADHS responded to the Governor's calls to action. As part of the declared state of emergency, ADHS was given the responsibility to:

- Provide consultation to the Governor on identifying and recommending elements for an Enhanced Surveillance Advisory.
- Initiate emergency rulemaking for opioid prescribing and treatment within health care institutions.
- Develop guidelines to educate providers on responsible prescribing practices.
- Provide training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations.
- Provide a report to the Governor on findings and recommendations by September 5, 2017.

ENHANCED SURVEILLANCE ADVISORY

With consultation from ADHS, Governor Ducey issued an executive order on June 15, 2017 to require the reporting of opioid-related data, allowing State health officials to receive information within 24 hours of specific events. This was a first step toward understanding the current opioid burden in Arizona and building recommendations to better target prevention and intervention. These reporting require-

ments greatly increased the Department's ability to assess and apply timely interventions in comparison with traditional data sources, which are 6 to 18 months delayed. The specific health conditions required in the enhanced surveillance advisory included suspected opioid overdoses, suspected opioid deaths, naloxone doses administered in response to either condition, naloxone doses dispensed, and neonatal abstinence syndrome.

To facilitate collection of data, the agency's secure web-based surveillance systems, Medical Electronic Disease Surveillance Intelligence System (MEDSIS) and Arizona Prehospital Information & EMS Registry System (AZ–PIERS), were utilized for designated reporters to electronically submit mandatory surveillance data. These systems were quickly modified to accommodate data submitted from 209 unique MEDSIS reporters and 143 AZ–PIERS reporters. ADHS coordinated a series of three webinars that trained a total of 171 health care, EMS, and law enforcement reporters. Arizona State Public Health Laboratory established the capability to receive postmortem blood specimens from Medical Examiners Offices to screen suspected opioid overdoses for opioids and other substances as of April, 2018.

TREATMENT CAPACITY SURVEY

In order to ascertain the current capacity and occupancy for substance abuse treatment in the State, ADHS requested the completion of an anonymous behavioral health, substance abuse treatment, and health care facilities survey. The survey was disseminated through the Regional Behavioral Health Authority system. Survey data was used to gain a better understanding of the distribution of services across the State, understand the utilization and availability of treatment, and better target future resources for treatment capacity in Arizona. Overall, the data collected demonstrated that there are not an adequate number of treatment services available in the State. It was also noted that when seeking care, many individuals may be turned away or placed on waiting lists. Starting in September 2018, ADHS will be collecting treatment capacity data from health care facilities and will issue quarterly reports noting gaps and recommendations.

EMERGENCY RULE MAKING

As directed in the emergency declaration, the Department rapidly initiated emergency rule making for opioid prescribing and treatment practices in licensed health care institutions. Rules were completed in coordination with Arizona's Attorney General's Office and approved by the Secretary of State for immediate implementation on June 28, 2017. These emergency rules focus on health and safety; provide regulatory consistency for all health care institutions; establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment; include specific processes related to opioids in a health care institution's quality management program, and require notification to the Department of a death of a patient from an opioid overdose. To support the agency's stakeholders and partners, a series of four webinars on the emergency rules were held, training a total of 458 attendees.

After the emergency rule implementation, the Department initiated the regular rule-making process, which included opportunities for stakeholder input on the final rules through several stakeholder workgroup meetings and surveys in September and October 2017. An oral proceeding was held on December 18, 2017. Written comments were accepted through December 18, 2017. The final rules went into effect March 6, 2018.

In addition, ADHS drafted and submitted emergency opioid-related reporting rules to the Attorney General's Office in order to maintain reporting requirements initiated by the Enhanced Surveillance Advisory. These rules require continued reporting of suspected opioid deaths, suspected opioid overdoses, naloxone doses administered in response to a suspected opioid overdose, naloxone doses dispensed, and neonatal abstinence syndrome cases. On-going reporting requirements will allow sustainable and continued collection of timely data throughout Arizona to better target prevention. Following stakeholder meetings and surveys through the regular rule-making process, the opioid-related reporting rules went into effect on April 5, 2018.

OPIOID PRESCRIBING GUIDELINES

ADHS utilized the Arizona Prescription Drug Initiative Health Care Advisory Team, which has been in place since 2015, to review and update the Arizona Opioid Prescribing Guidelines published in 2014. The Rx Initiative Health Care Advisory Team, made up of professional health care associations, practicing clinicians, and subject-matter experts, met 9 times since June 2017 to review and update the guide-

lines. The Guidelines are a voluntary, consensus document that promotes patient safety and best practices if prescribing opioids for acute and chronic pain. Nineteen Arizona healthcare organizations have endorsed the new guidelines. The content of the guidelines was finalized in December 2017, and the final version is posted at *www.azhealth.gov/opioidprescribing/*.

Current updates reflect:

- Incorporation of the most recent evidence, National guidelines (including the VA/DoD *Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, 2017 and *CDC Guideline for Prescribing Opioids for Chronic Pain*, 2016), best practices from other States, and Arizona data.
- A shift in pain care that avoids unnecessary exposure to opioids in order to reduce the risk of adverse outcomes. Previous guidelines focused on the "safe prescribing" of opioid therapy, while these guidelines aim to prevent initiating unnecessary opioid therapy while addressing patients' pain from a whole-person perspective.
- Emphasis on non-stigmatizing language. Health care providers can counter stigma by using accurate, nonjudgmental language. These guidelines employ person-first language ("Patients with substance use disorder" instead of "addicts"), nonjudgmental terminology ("negative urine drug test" instead of "dirty") and supportive terms ("recovery" instead of "no cure").
- Increased focus on prevention, recognition, and treatment of opioid use disorder in patients receiving long-term opioid therapy for chronic pain, given the high risk of developing opioid use disorder in this population.
- Integration into clinical workflow (operationalization). A key element of success of guideline implementation is how seamlessly it can be incorporated into a clinician's normal activities. This revised version includes specific operationalization actions under each guideline.

EXPANDING ACCESS TO NALOXONE

ADHS identified a need to train local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations, in order to positively impact the opioid epidemic through rapid treatment of encountered suspected overdoses. Approximately 1,000 law enforcement officers have been educated through training events held throughout the State since June 2017. ADHS is coordinating continuing requests for law enforcement training with the Arizona Peace Officer Standards and Training Board (AZ–POST).

Progress on naloxone distribution includes:

- ADHS has free naloxone kits available for law enforcement agencies and first responders who are unable to bill for naloxone. Agencies can request naloxone by completing the request form on the ADHS website.
- ADHS has provided 6,316 naloxone kits for 63 law enforcement agencies since June 2017.
- ADHS received a SAMHSA grant to support training of first responders in naloxone administration and conducting screening, brief intervention, and referral to treatment. AzPOST and the University of Arizona are partnering with ADHS to implement grant activities.
- Eighty-four percent of people experiencing non-fatal overdoses since June 15, 2017 when enhanced surveillance was initiated received naloxone pre-hospital.
- Law enforcement officers have administered naloxone 482 times to 364 people since June. In all but 9 cases, the individual survived the immediate out-of-hospital event.

In order to support increased use of naloxone to save lives in Arizona, ADHS Director Dr. Cara Christ signed standing orders that allow pharmacists to dispense naloxone to any individual in the State and allow ancillary law enforcement, correctional officers, and EMS to use naloxone for suspected opioid overdoses. A naloxone pamphlet was developed in both English and Spanish to assist in public education of opioid safety and naloxone use.

GOAL COUNCIL 3: OPIOID BREAKTHROUGH PROJECT

With Director Cara Christ as the lead of the Governor's Goal Council 3 on Healthy People, Places, and Resources, the ADHS team assisted Director Christ in launching several subgroups to recommend actions that will reduce opioid deaths. On June 26, 2017, partners from across the State convened to learn more about the opioid emergency and the work of the Goal Council on Healthy People, Places, and Resources.

Participants were asked to join one or more subgroups to help define problems, set goals, and determine what actions would be most impactful to prevent and re-

duce opioid deaths. Subgroups worked together in July and August 2017 to identify recommendations and convened again on August 23, 2017 to share draft recommendations. Approximately 200 committed Arizonans volunteered their time to contribute ideas and prioritize recommendations that shaped much of the content of the recommendations in Opioid Action Plan delivered by ADHS to Governor Ducey. Over the course of the emergency declaration, ADHS has held over 50 stakeholder meetings and engaged over 1,350 Arizonans State-wide.

COMMUNICATION AND RESOURCES

ADHS has developed several mechanisms to allow for partner interaction and information distribution. One such mechanism is the development of a dedicated webpage, *azhealth.gov/opioid.* This webpage organizes resources and allows stakeholders to quickly access up-to-date opioid-related information. Within these webpages the Department has posted numerous unique resources covering various topics including FAQs, reporting-related case definitions, publicly released data, setting-specific guidance and resources, and a 50 State Review on Opioid Related Policy. A centralized email, azopioid@azdhs.gov, and digital interface within the opioid webpage allow for direct stakeholder communication for concerns and interest in partnering with the Department.

ADHS recently formed a drug overdose mortality review team, per § A.R.S. 36–198, to develop a data collection system regarding drug overdoses, conduct an annual analysis relating to drug overdose fatalities, develop standards and protocols, provide training and technical assistance to local overdose review teams, and develop investigation protocols for law enforcement and the medical community. The first meeting of the State Drug Overdose Fatality Review Team was held on November 28, 2017.

ADHS is also launching a new approach adopting chronic pain as a public health issue. In follow-up to a chronic pain summit held in May 2017, ADHS developed a dedicated webpage, *azhealth.gov/chronicpainmanagement,* to increase public awareness and utilization of safe, effective approaches to managing chronic pain. With an emphasis on promoting non-pharmacological therapies that are proven to ease pain and increase function, ADHS aims to help Arizonans with chronic pain resume daily activities and maximize their quality of life. A major component of this initiative will be a new media campaign emphasizing options and self-management strategies for addressing chronic pain.

ARIZONA OPIOID ACTION PLAN

The public health emergency declaration directed the Arizona Department of Health Services to submit a report of the accomplished activities and identify recommendations for combating the opioid epidemic in Arizona. ADHS submitted the Opioid Action Plan to Governor Ducey on September 5, 2017. The Opioid Action Plan includes 12 major recommendations with over 50 actions slotted for completion by June 30, 2018.

Goals to address the opioid epidemic:

- Increase patient and public awareness and prevent opioid use disorder.
- Improve prescribing and dispensing practices.
- Reduce illicit acquisition and diversion of opioids.
- Improve access to treatment.
- Reduce opioid deaths.

Recommendations, created through multiple meetings with partner agencies, impacted stakeholders, Goal Council 3 subgroups, and policy makers to address the above goals include:

1. Enacting legislation that impacts opioid deaths by addressing identified barriers;
2. Creating a free, State-wide consultative call line resource for prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder;
3. Requiring Arizona medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum;
4. Engaging the Federal Government to address necessary Federal-level changes;
5. Establishing a regulatory board workgroup to identify prescribing trends and enforcement issues;
6. Encouraging law enforcement agencies to expand the Angel Initiative and other existing diversion programs and assist the DEA with filling local vacancies on the Tactical Diversion Squad;

7. Increasing access to naloxone for high-risk individuals released from correctional facilities;
8. Pulling together experts into task forces to address identified barriers by:
- Identifying specific improvements to enhance the Arizona Controlled Substance Prescription Monitoring Program;
- Identifying, utilizing, and building upon Arizona's existing peer recovery support services;
- Providing recommendations regarding insurance parity and standardization of substance abuse treatment and chronic pain management across the State; and
- Identifying and implementing school-based prevention curriculum, expanding after school opportunities and identifying resource needs.

Goal	Recommendations	Progress to Date (May 2018)
Reduce Opioid Deaths.	Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment.	On January 26, 2018, Governor Ducey, with unanimous, bipartisan support of the Arizona Legislature, passed the Arizona Opioid Epidemic Act, or Senate Bill 1001, a comprehensive approach to addressing opioid related issues State-wide.
Improve Prescribing & Dispensing Practices.	Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues.	ADHS convened three meetings of the Regulatory Board Workgroup and will submit an Action Plan to the Governor by June 30, 2018.
	Establish a task force to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP).	The Arizona Board of Pharmacy convened the task force and identified a set of initial improvements regarding registration of prescribers and improved outreach, technical assistance, and education. New training modules are available on how to use the Arizona Controlled Substances Prescription Monitoring Program on their website.
Reduce Illicit Acquisition & Diversion of Opioids.	Meet with leaders of law enforcement and first responder agencies to expand Angel Initiative and other OUD diversion programs and assist the DEA with filling vacancies in the DEA Tactical Diversion Squad.	ADHS and Homeland Security leadership met with law enforcement leadership in September.
		Two law enforcement agencies are participating in the Angel Initiative with 136 individuals enrolled.

Goal	Recommendations	Progress to Date (May 2018)
Improve Access to Treatment.	Require all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum. Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder. Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services. Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the State. Engage the Federal Government outlining necessary Federal changes to assist Arizona with our response to the opioid epidemic. Increase access to naloxone and Vivitrol for individuals leaving State and county correctional institutions and increase access to MAT therapy for individuals with opioid use disorder while incarcerated.	ADHS has worked with 100 percent of Arizona academic partners to develop a Statewide curriculum on opioid prescribing, treatment of opioid use disorder and management of chronic pain. The Opioid Assistance and Referral Line, a free 24/7 call resource for prescribers, has been implemented in partnership with Arizona's Poison and Drug Information Centers. Arizona's Medicaid agency and State substance abuse authority, AHCCCS, has convened the peer support work group. The Task Force conducted a survey of current insurance coverage related to pain management and opioid use disorder treatment. A report with recommendations will be submitted to the Governor by June 30, 2018. The Governor's office sent the letter requesting Federal changes to assist Arizona's response to the opioid epidemic. ADHS is working with the Arizona Department of Corrections to implement a naloxone pilot program for formerly incarcerated individuals who are at high risk for overdose after release. ADHS has provided 1,000 doses of naloxone for Corrections to distribute to high-risk inmates being released. An overdose prevention and education video will be completed June 30.
Prevent Opioid Use Disorder/ Increase Patient Awareness.	Utilize Public Service Announcements (PSAs) to educate patients, providers, and the public regarding opioid use and naloxone. Create a youth prevention task force to identify and implement evidence-based, emerging, and best practice substance abuse prevention/ early identification curriculum, expand after-school opportunities, and identify resource needs.	The Governor's Office of Youth, Faith, and Family developed new PSAs that began airing in December and are scheduled to continue through 2018. See *www.RethinkRxabuse.org*. The Governor's Office of Youth, Faith, and Family has convened the youth prevention task force to discuss prevention programs. A report with recommendations will be submitted to the Governor by June 30, 2018.

ARIZONA OPIOID EPIDEMIC ACT

On January 26, 2018, Governor Doug Ducey signed The Arizona Opioid Epidemic Act, the first bill to become law in 2018, following a 4-day Special Session and unanimous passage in the House and Senate. The legislation takes aggressive steps to address opioid addiction, hold bad actors accountable, expand access to treatment, and provide life-saving resources to first responders, law enforcement, and community partners. Most provisions of the act went into effect on April 26, 2018.

Specific policy initiatives in the Arizona Opioid Epidemic Act include:

- Identifying gaps in and improving access to treatment, including for uninsured or underinsured Arizonans, with a new $10 million investment;
- Expanding access to the overdose reversal drug, naloxone, for law enforcement or corrections officers currently not authorized to administer it;
- Holding bad actors accountable by ending pill mills, increasing oversight mechanisms, and enacting criminal penalties for manufacturers who defraud the public about their products;
- Enhancing continuing medical education for all professions that prescribe or dispense opioids;
- Enacting a Good Samaritan law to allow people to call 9–1–1 for a potential opioid overdose;
- Cracking down on forged prescriptions by requiring e-prescribing;
- Requiring all pharmacists to check the Controlled Substances Prescription Monitoring Program prior to dispensing an opioid or benzodiazepine;
- Developing a social media youth prevention campaign;
- Requiring emergency departments and hospitals to make referrals to treatment for overdose patients;
- Reducing prior authorization time frames for insurers and requiring insurers to make at least one form of Medication Assisted Treatment available without prior authorization;
- And, limiting the first-fill of an opioid prescription to 5 days for all opioid naïve patients and limiting dosage levels to align with Federal prescribing guidelines. These proposals contain important exemptions to protect chronic pain suffers, cancer, trauma or burn patients, hospice or end-of-life patients, and those receiving dication assisted eatment for substance use disorder.

EXPANDING ACCESS TO TREATMENT

Arizona is expanding access to opioid use disorder treatment and support resources through Federal and State funding.

- Arizona received $24 million dollars through the SAMHSA State Targeted Response (STR) Grant to use toward opioid use disorder prevention and treatment. The Arizona Health Care Cost Containment System (AHCCCS) is expanding access to opioid treatment programs throughout the State using grant funds from SAMHSA. The first of five, 24-hour centers for opioid treatment, including two medication-assisted treatment (MAT) centers and three crises centers, opened in October 2017 to address the growing need for access to opioid use disorder treatment. The 24/7 access to opioid treatment is currently available in Mohave, Yavapai, Maricopa, and Pima counties.
- The Arizona Opioid Epidemic Act provided $10 million in State general fund dollars for substance use disorder services for the uninsured and underinsured. AHCCCS conducted community forums to gather input to target use of the funding and identify priority needs.

ARIZONA'S PROGRESS

- 100 percent (18/18) of health professional schools in Arizona participated in development of a curriculum for pain and addiction. This is the Nation's first State-wide curriculum across all prescriber training programs. All schools agreed to a shared vision to redefine pain and addiction as multidimensional, public health issues that require the transformation of care toward a whole-person approach with a community and systems perspective. Academic programs are expected to begin integration of core components of the curriculum during the 2018–19 school year.
- New OARLine: Opioid Assistance + Referral Line for Arizona Providers: 1–888–688–4222 is available for health care clinicians to call for free consultation on patients with complex pain or opioid use disorder. The 24/7 hotline is staffed by experts at the Poison and Drug Information Centers in Arizona. The hotline will be expanded in the future to provide information and referrals to the public.

- ADHS is working with the Arizona Department of Corrections on a pilot to provide released inmates at high risk of opioid overdoses prevention education and naloxone. Training was conducted for corrections supervisors on naloxone, and 1,000 naloxone kits have been provided for them to begin distributing to those inmates who are identified at risk for an overdose post-release. (High-risk was defined as overdosing while incarcerated) ADHS is also working on a short educational video to be completed by June 30.
- The Insurance Parity Taskforce conducted a survey of over 50 insurers to assess current coverage of pain management treatments and substance use disorder treatments. The Taskforce will make recommendations to Governor Ducey by June 30, 2018.
- ADHS and Governor's Office of Youth, Faith, and Family will be launching a new youth prevention campaign in fall of 2018, which was authorized and funded by the Arizona Opioid Epidemic Act.
- ADHS is working with stakeholders to develop new regulations for pain management clinics. Arizona will license pain management clinics starting January 2019.

While it is early to evaluate the outcomes associated with Arizona's response to the opioid crisis, there are some promising indicators of success.

- The 4 & 4 report is a list of patients who have obtained controlled medications from 4 different doctors and 4 different pharmacies in a given month. The Arizona Board of Pharmacy sends any prescriber with a patient on the 4 & 4 list an unsolicited letter to alert the prescriber of the patient's possible doctor and pharmacy shopping. There has been a 60 percent decline in the number of patients on this report—from 99 in July 2017 to 40 in April 2018.
- The percent of patients receiving referrals to behavioral health or substance abuse treatment services after an overdose has increased from 41 percent in June 2017 to 63 percent in April 2018.
- The number of naloxone prescriptions dispensed by pharmacists has increased significantly in recent months. July–September 2018, fewer than 900 naloxone kits were dispensed each month. In April 2018, 3,143 kits were dispensed to the public. See attachment 1.
- The number of opioid prescriptions filled and the number of prescriptions with high doses exceeding 90 morphine milligram equivalents has declined, as illustrated in the graphs in attachments 2 and 3.

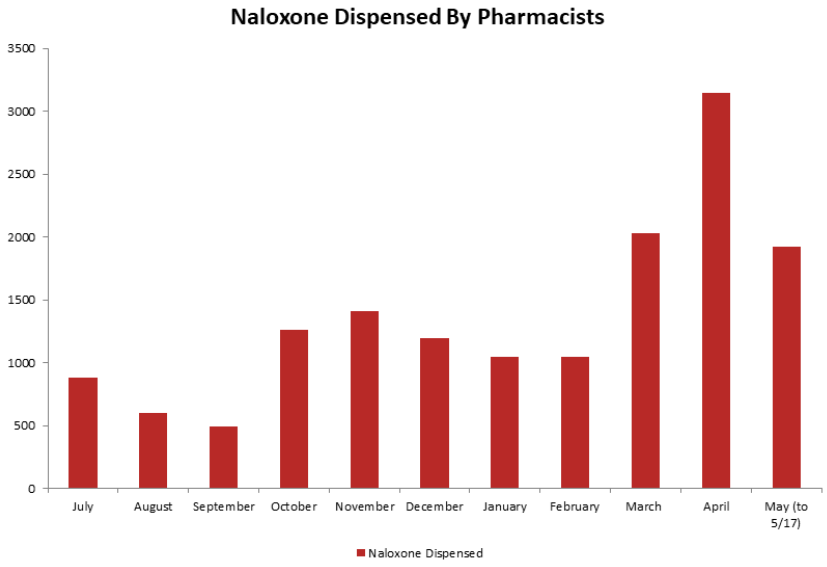
LESSONS FROM OPIOID SURVEILLANCE

ADHS has been collected data on suspected opioid overdoses since June 15, 2017. Over this period of time, the surveillance has indicated:

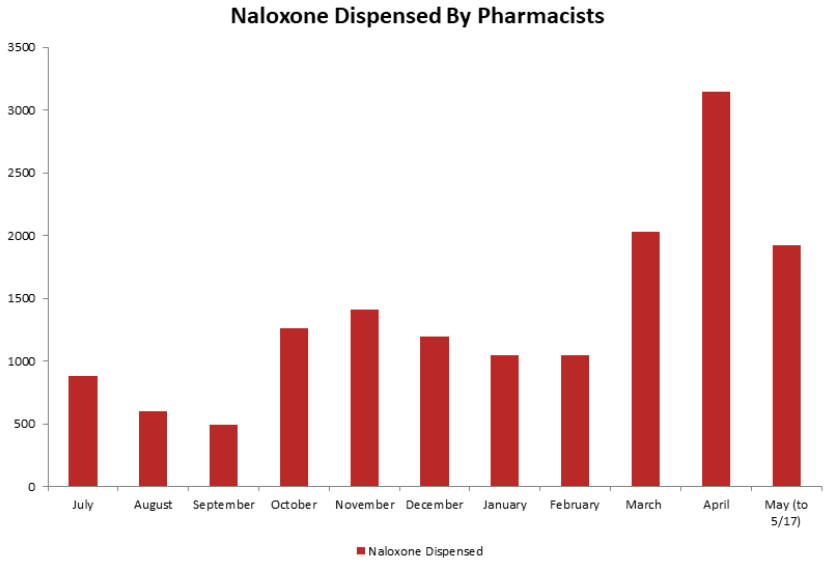
- Most overdoses (59 percent) occur among men.
- People ages 25–34 years old had the highest percent of suspected opioid overdoses.
- Chronic pain (e.g. lower back pain, joint pain, arthritis) is the most common pre-existing physical condition reported for those who had a verified opioid overdose, followed by depression and history of substance use disorder, including alcohol.
- About 40 percent of people who had a suspected overdose (between June 15, 2017 and March 26, 2018) had 9 or more prescriptions for opioids filled.
- More than 40 percent of people who had a suspected opioid overdose were prescribed opioids by 10 or more providers since January 2017.
- Most reported overdoses involve multiple drugs. Polydrug use was indicated in 2/3 of the overdose fatalities. The charts in attachments 4 and 5 detail the drugs identified in the reported opioid overdoses.

NUMBER OF NALOXONE KITS DESPENSED BY PHARMACIES

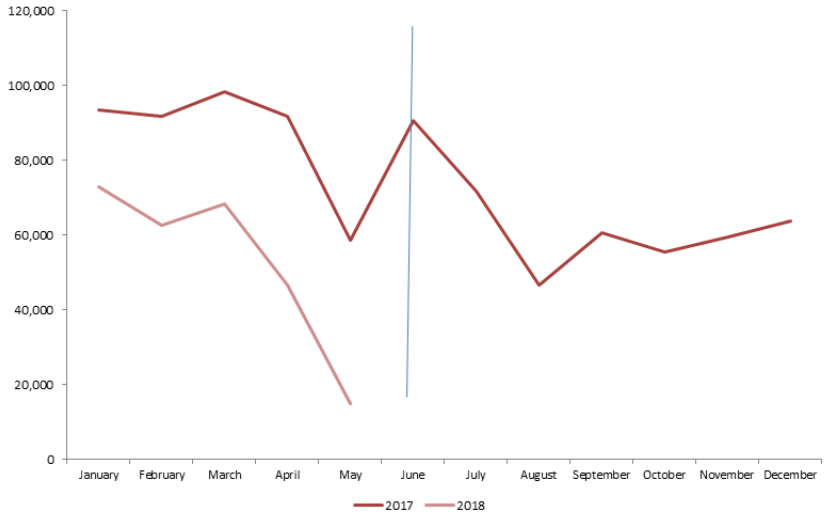
CONTROLLED SUBSTANCES PRESCRIPTION DRUG MONITORING PROGRAM DATA JULY 1, 2017–MAY 17, 2018



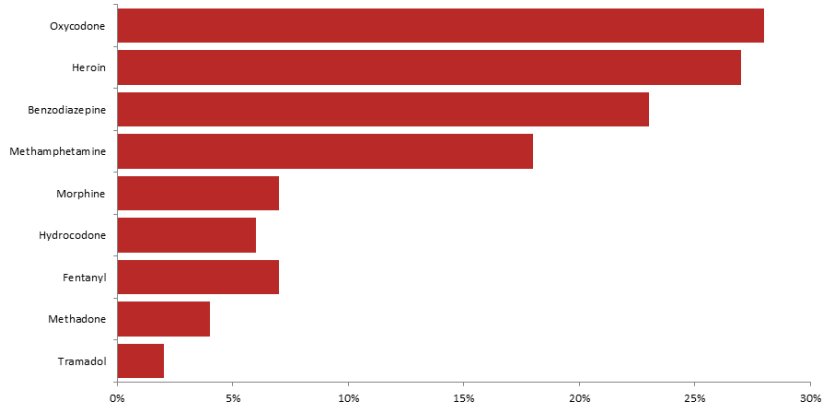
OPIOID PRESCRIPTIONS FILLED PER MONTH. CONTROLLED SUBSTANCES PRESCRIPTION DRUG MONITORING PROGRAM DATA JAN. 1, 2017–MAY 10, 2018



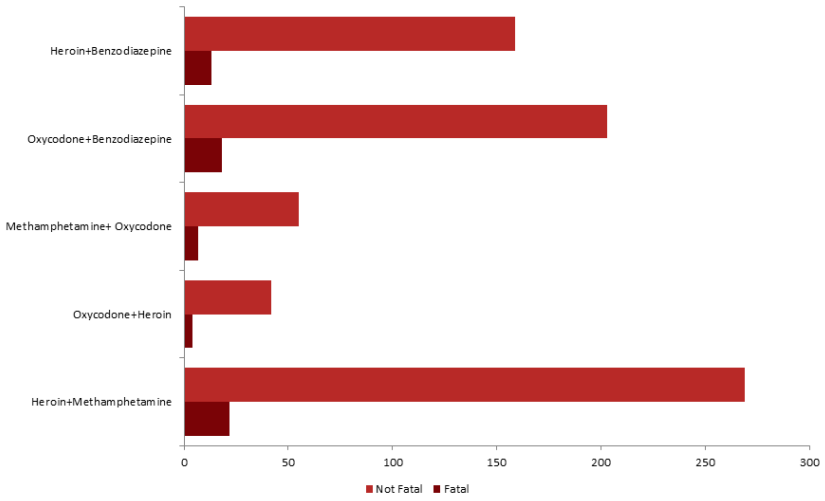
NUMBER OF OPIOID PRESCRIPTIONS FOR MME 90 OR ABOVE FILLED PER MONTH. CONTROLLED SUBSTANCES PRESCRIPTION DRUG MONITORING PROGRAM DATA JAN. 1, 2017–MAY 10, 2018



OXYCODONE AND HEROIN WERE THE OPIATE DRUGS MOST COMMONLY NOTED IN OVERDOSES DETERMINED TO BE DUE TO OPIOIDS DURING REVIEW. OVERDOSE SURVEILLANCE DATA JUNE 15, 2017–MAY 17, 2018



NUMBER OF NALOXONE KITS DESPENSED BY PHARMACIES. OVERDOSE SURVEILLANCE DATA JUNE 15, 2017—MAY 17, 2018



Ms. MCSALLY. Thank you, Dr. Christ.

The Chair now recognizes Dr. Segay to testify for 5 minutes.

STATEMENT OF GLORINDA SEGAY, M.D., HEALTH DIRECTOR, DIVISION OF HEALTH, THE NAVAJO NATION

Dr. SEGAY. Thank you, Madam Chair. I am Dr. Segay, Navajo Nation executive director for Department of Health. The president and vice president also send their regards. Thank you for having me here today, and thank you for all that you do for us.

I just want to also inform you that opioid abuse does exist on the Navajo Nation. Recently we had created an opioid task force team, and basically this is a collaboration with our Indian Health Service. We do have five facilities there on Navajo, and also our Public Law 93–638 facilities which we also have there.

Basically, we have been talking about how and what is this opioid to the Navajo Nation. Our people there have a low health literacy rate in regards to understanding what is happening in their health, so that is what we have been talking about, APSA and creation of educating our Navajo Nation in ways that opioids that are being used on Navajo, which we discussed, is the pill form, the smoking, the snorting, mixing with substances, skin patches. So basically we are working on a PSA again so that we can educate our Navajo people.

One barrier we do have is our language. Navajo language is very complex, so it is a lot of descriptive details that we need to include while we are translating. So we do have issues with funding there, so we do need and request more funding so that we can provide adequate services in educating our Navajo people.

We do have distributors there on Navajo. The main distributor is Indian Health Service, and also our Public Law 638 facilities. We do have border towns there, such as Flagstaff and Gallup, so they

do have their private distributors such as Walmart, Walgreens, and Safeway, which we have no control of, so that is an issue for us.

It is also furthermore requesting as far as Tribal direct funding. It is very hard when the Government sends money to the State and then it trickles to the Tribes. There are restrictions and there is not enough funding.

I also just want to make mention that AHCCCS is underfunded. So if we can get more funding to AHCCCS to help us to fight opioid there with Navajo as well as Indian Country. We have been talking with AHCCCS, and what we do have is a strategic plan that has been shared with us. Part of the strategic plan is basically strengthening our public health data and reporting and collecting. We want to focus on actionable data for target interventions so that we can provide services.

I just also want to make mention that with Navajo, one of our methods of treatment is through our traditional Native medicine. So we still do use our elders. We still use our cultural practices through prayers and songs and chants with our ceremonies, and that is very effective for us. So we do also want that to be recognized as a form or method of treatment.

Furthermore, just going on with our strategic plan, we have an advanced practice of pain management to enable access to high-quality, evidence-based pain care that decreases the burden of pain for individuals, families, and society, while also reducing them in appropriate use of opioids and opioid-related harms.

So again, going into the crime rate, we do have a high level of crime, underlying issues with domestic violence. We also have human trafficking there on Navajo because of opioids, as well as other substances.

We want to improve access for patients as far as treatment, prevention, and recovery services so that we can prolong the life of each of our Navajo people. They are important to us. We also want to target the availability and distribution of overdose medication to ensure the provision of these drugs to people likely to experience or respond to an overdose, with a particular focus on targeting high-risk population.

I also want to make mention that we also want to support cutting-edge research that advances our understanding of pain and addiction that leads to development of new treatment and identifies effective public health interventions to decrease opioids. So right now what we are basically doing is a lot of prevention education. We do have a collaboration with our community health representatives, who also go out into the community and pretty much provide education in the Navajo language, and we also feel our Navajos learn more visually. So they are out there with their charts, especially with our elders and speaking about what are the signs and the symptoms, what are some concerns, because a lot of our people who use opioids still live with their elderly parents. So we want to inform the elderly parents because, again, it is a safety concern. We get a lot of elders who come to us and tell us that they are afraid of their adult children, especially when they are on any sort of influence as far as substances go.

I also want to make mention that Navajo Nation president has made mention several times there in the District of Columbia that

the DEA needs to be involved and that we feel as Navajo they need to place extreme restrictions on opioids.

Basically, that is what I wanted to share with you all. Thank you for this time.

Ms. MCSALLY. Thank you, Dr. Segay.

The Chair now recognizes Ms. Moak for 5 minutes to testify.

STATEMENT OF DEBBIE MOAK, CO-FOUNDER, NOT MY KID

Ms. MOAK. Chairwoman McSally and distinguished Members of Congress, thank you for having me here today. It is an honor.

Generally, when we talk about opioid abuse or drug abuse in general, we think about three different buckets: Supply, demand, and harm reduction strategies. I am going to focus my comments primarily on demand and touch on harm reduction strategies.

In the midst of an opioid epidemic, I want to see people find access to treatment to save lives while preventing the next generation from starting down this path. We must do both simultaneously.

About a decade before we founded notMYkid, drug abuse was the No. 1 issue on the minds of Americans. This country went to work, and we made huge strides in and from all sectors. Yes, it was law enforcement, but it was also everyone else too, including Hollywood, churches, sports professionals. This country knows how to take an issue, like we have done with tobacco use, seriously when it wants to, and in the late 1980's and early 1990's, we did that.

The results were nearly miraculous. We reduced drug abuse in this country by over 50 percent by 1993 when we got focused. We did in this country what we too often do: We felt we solved it, and we moved on. So we should look back to those years and look at those strategies of what worked.

I will tell you this: We need to adopt those strategies and funding consistently and grind them out without gaps year after year.

Too often I am dismayed because I hear smart, responsible citizens tell me that it is impossible to turn back our drug use problem here in the United States, and I say you are wrong. It must start first with our will to do so. The mass poisoning of millions can be stopped with a serious effort.

We have addressed drug crises like crack cocaine, crystal meth, and now must employ similar strategies for the opioid epidemic. We actually know what to do. We have been here before. But every single American has a role to play.

Yes, I said substance use, because I don't just single out opioids, even in the midst of a crisis. America has a drug use problem. Of course, we see whatever is coming across our borders, what is coming through our postal system, and what is being produced here in America. That will trend what we are seeing that ends up in our homes, depending on what the supply is. Addressing demand or use of all substances needs to also be done simultaneously. That is the best evidence-based practice, versus singling out one substance.

I want to share with you some effective programs that are happening here in Arizona that can be employed more widely. Our Arizona Use Survey of 2016 is a road map for us. It tells us that youth use drugs for the following reasons, and in order: To have fun, to feel good, to deal with stress, and to avoid being sad. In other

words, youth want to alter how they feel. Sadly, adults have sent them many messages that impact that thinking.

We have told kids that things like marijuana is medicine when we vote to change medicine to recreate with it. We see commercials every time we turn on the TV that tell us there is a fix for every feeling that we have.

The survey also gives us a road map, however, for how to keep kids from using drugs. The top reasons why kids don't use drugs are: It is of no interest to them; they understand the harmful effects; they don't want to disappoint their parents; and that they are illegal. These are all points of data.

Arizona has a campaign unlike the "Just Say No" campaign. Arizona has a campaign called—I call it a "Just Say Yes" campaign. Say yes to I have something better to do. We connect youth to local opportunities in their counties to play sports, hike mountains, go to a concert, volunteer and, quite frankly, get reengaged with their own families.

We have to inspire kids to seek out their passions and dreams and help them to get there. When was the last time we have seen a great PSA or campaign continued not only throughout the year without interruption here in Arizona and certainly across the United States? We can do that, and Arizona already has a great campaign ready to be scaled.

We also know that talking to our kids with an educated parent may reduce substance abuse by 50 percent. Yet, the Arizona Youth Survey shows us that only 50 percent of 8th graders have had that conversation with a parent in the last year. Sixty percent of seniors have not had that conversation with a parent in a year. Fix that. Focus on that. Mandatory parent, youth, and faculty involvement in prevention programming that educates youth, parents, and faculty at the same time exists here in Arizona. However, that program has great data provided by ASU in its reach, and we won't have funding for it next year.

SBIR, one of the 56 Opioid Commission recommendations: Screening, brief intervention, referral to treatment. Yes, screen all high school students for mental health and substance use. Ninety percent of all addiction occurs from what kids do during the teen years. That gives us our target and a bulls-eye. Screen youth during these years to support and intervene early when it is easy to turn the situation around, when it is least costly to youth and society. We used to screen kids for things like vision or scoliosis, and when we screen all kids, it is not weird and no one gets singled out or stigmatized.

When notMYkid has a program where kids are being funneled there who have been caught with first use, and it has tripled in a year in its size because schools are desperate for this, it is called Project Rewind.

So on first use of a kid, we work with them. Kids shouldn't be kicked out of school. We should help them and their families receive appropriate resources; again, something else that already exists and we can scale.

Youth feel loved and protected when adults set boundaries and offer support. Today's youth feel alone, isolated, and stressed more than ever. This is a place for adults to get educated and connect,

and I am letting you know that embedding behavioral health in our schools is key.

Ms. MCSALLY. Ms. Moak, can you wrap up your testimony and we will continue on with the questions?

Ms. MOAK. Oh, I am so sorry. Yes, ma'am. I am so sorry.

Ms. MCSALLY. That is OK.

Ms. MOAK. As you can see, I am quite passionate.

Ms. MCSALLY. You are.

Ms. MOAK. Then in closing I will just say there are five things I would like you to remember.

Prevention is the healthiest and cheapest.

The Federal Government must provide visible leadership to convene all parties.

We must recognize behavioral health as important as education in school settings.

We need on going public- and private-sector commitments.

We must make access to treatment available.

Thank you.

[The prepared statement of Ms. Moak follows:]

PREPARED STATEMENT OF DEBBIE MOAK

I want to thank this committee for addressing this serious issue, this most serious of issues. Generally, when speaking to an audience like this I would address supply, demand, and harm reduction strategies. Knowing the expertise of the other panel members today I will focus my comments on demand and touch on harm reduction. In the midst of an opioid epidemic I want to see people find access to treatment to save lives, while preventing the next generation from starting down this path. We must do both simultaneously.

The context for my comments today come from 10 years as a classroom teacher, behavioral health education, 20 years in non-profit prevention, previous director for Governor Ducey's Office of Youth, Faith, and Family and someone who's been in the trenches with her own family and thousands of other families for 20 years with addiction.

About a decade before we started notMYkid, drug abuse was the No. 1 issue on the minds of Americans. This country went to work and we made huge strides—in and from all sectors. Yes, it was law enforcement, but it was also everyone else, too—from schools to churches to synagogues to Hollywood to professional sports. This country knows how to take an issue, like we've done with tobacco use, seriously when it wants to and in the late 1980's and early 1990's we did.

The results were nearly miraculous. We reduced drug abuse in this county by over 50 percent by 1993. And then we did in this country what we too often do: We moved on. We should look back to those years and use those successful strategies. We've done this before, we can do this again. We must first have the will and focus to grind these strategies out, year after year without fail. This should be one of our most diligent efforts and focused priorities as a Nation. Too often I hear smart, responsible citizens say that it's impossible to turn America's drug use around and I say, you're wrong! The mass poisoning of millions can be stopped with a serious effort. Anyone who actually believes that we can't do this is part of the problem, not the solution.

We have addressed drug crisis before including crack cocaine, crystal meth, and now must employ similar strategies to the latest epidemic, opioids. We actually know what to do as we've been here before. Every single American has a role to be played in reducing substance use. Yes, I said substance use vs. singling out opioids. America has a drug USE problem. Of course we see use trends spike as different drugs make it across our borders, through our U.S. Postal Service and onto our streets. Yes we must specifically address the opioid epidemic with urgency, but we must also begin to see the pattern. Both what comes across our borders and what is produced here, be it spice, molly, bath salts and more, are what citizens will use. In short, we have a USE problem in the United States. Addressing demand or use on-going of ALL substances must be consistent and evidenced based year after year.

Let's first take a look at some successful prevention strategies employed here in Arizona, but with intermittent or no continued funding sources to continue annually. We must prevent future generations from following the path of drug use and abuse.

The Arizona Youth Survey 2016 tells us that youth use drugs to have fun, feel good, deal with stress and avoid being sad. In other words, youth want to alter how they feel through a drug, and adults have sent them that message in so many ways. We've told kids things like marijuana is medicine when we vote to change medicine so we can recreate with it, we see commercials every time we turn on the TV that tell us there's a fix for every feeling we have just ask your doctor for this pill. But the survey also gives us a roadmap for how to keep them from using drugs. The top reasons why kids don't use drugs are: It's of no interest in them, they understand the harmful effects, they don't want to disappoint their parents, and they're illegal. All points of data that we can implement like the campaign we started here in the State of Arizona. Instead of the "Just Say No" campaign Arizona has created a just say yes campaign. Say yes to "I've Got Something Better To Do". Connecting youth to local opportunities to play sports, hike the mountains, listen to a concert, or volunteer connects them to their passions, dreams, and families. When people in our country shame, stigmatize, and don't want to spend money to help those with a chronic, relapsing, brain disease, I often think, do they not remember that the average age of first use in this country is 13. We're talking about helping people who began their drug use as a teenager. Funding for this campaign is intermittent at best and must be sustained year-round for maximum impact.

We all know that talking regularly with an educated parent about substance abuse can reduce drug use by about 50 percent. Yet, the Arizona Youth Survey shows us that 50 percent of AZ 8th graders and their parents didn't talk about drugs in the last year and almost 60 percent of seniors didn't hear from their parents either. Fix that, focus on that, mandatory parent, youth, and faculty involvement in drug education like the program we launched in Arizona, Healthy Families Healthy Youth, prevention programming that educates youth, parents, and faculty at the same time. These are researched-based and have great data to support the effectiveness of this program, but as is the norm, there will be no money to continue this cost effective, data-driven prevention program next year.

SBIRT-SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT

Yes, screen ALL high school students for mental health and substance use. Ninety percent of all addiction start in the teen years. Screen youth during these years to support and intervene early when it's easiest to turn the situation around, when its least "costly" to our youth and society. When we screen all youth in a school setting no one gets singled out, no one is weird, like vision screening used to be: It's preventative and helpful to connect youth and their families to resources. One such intervention program at notMYkid has tripled in size rapidly through school referrals, Project Rewind. When a kid is first caught with a substance we need to intervene to stop its progression vs. kicking them out of school. As we look at our schools across the country, I don't think anyone can deny that it's about schools, prevention, early diagnosis and connecting kids to resources. As we look back at all the school violence, someone or multiple someones knew there was a problem with the school shooters. We need to change school culture and create meaningful prevention programs with access to resources early. Youth feel loved and protected when adults set boundaries and offer support. Today's youth feel alone, isolated, and stressed more than ever. This is a place for adults to get educated and connect to our youth facilitated in school settings.

As we moved on from the early 1990's, the crisis came back and today we are at epidemic portions with over 64,000 Americans dying a year from drug overdoses. Every year now, we lose more people to drug overdose deaths than all the names gathered over 18 years on the Vietnam Memorial Wall. In the District of Columbia.

That, of course, is the worst of it—we haven't even begun to account for family breakup, social services being stretched, criminal activity and costs, workplace accidents, dropouts, and education deficits, ER admissions, lost productivity. Once we do—we're talking hundreds of billions of dollars to America on this one problem, this one problem that drives so many other problems. Please let me be clear, although I have written my share of checks to organizations to help someone get off the streets, find a treatment bed, or pay for a meal, I'd much prefer to invest in a system of prevention which offers the greatest rewards to the individual and society.

To those of us who know friends and family in rehab we know two things: (1) Those are the lucky ones, the fortunate ones. Most don't get to or find rehab. Ap-

proximately 23 million people need treatment for a substance use disorder annually, yet sadly, only about 10 percent will receive it. (2) Sobriety is a life-long commitment that is addressed every day. Recovery is not linear, but relapse does not have to be a part of a person's story. Relapse is all too common and I don't accept that norm. I have lived through this personally with a son and a sister. Fortunately my son is with me, but my sister is not.

I have spent, as do others, tens of thousands of dollars on detox and treatment just to see my investment of love and resources lost with a relapse. The scariest day of a recovering addict's life is the day they leave the treatment center. We literally have built and funded a system for decades that hasn't changed and worse yet, rewards failure by bad actors. To be clear, there are many wonderful treatment centers and even more trained and compassionate counselors who want to help people. But I fear, and my experience has been, that there are far too many in this field who prey upon individuals and families at one of their most vulnerable times in life. Most business models would be rewarded for success and innovation in their fields, but we financially reward those in this field more when they have terrible outcomes or no outcomes at all! Let's hold treatment centers accountable for verifiable outcomes. I know you're thinking that's impossible, but I assure you it is not. Through technology-assisted care, peer support programs, drug testing, and more we can and must know which treatment centers are doing the best job and reward them. This type of programming actually already exists. In all candor, I share with you the only technology that does all of this today, that I am aware of, which was created by my son Steve who is here with me today. That program is called True After Care. There are likely others in the field who do something similar and I want to know more about them as well. The bottom line is, let's fund what works and demand verifiable outcomes! Recovery needs to be a part of treatment. No one should leave a 30-day treatment program without a serious support system like True After Care to complete their journey into long-term sobriety.

So in conclusion I want you to remember five things: (1) Prevention is the healthiest and most affordable choice we can ever make decreasing demand for drugs, (2) The Federal Government must provide visible leadership to create and convene all Americans in this effort, (3) We must recognize behavioral health as equally important as getting an education and imbed programs into our schools, (4) We need ongoing public- and private-sector commitments, (5) Last, we must make access to treatment widely available.

Drugs will always be here, so our message of prevention must be the louder of the two. We've done this before, we can and must do this again as it is not an unknown science.

Ms. MCSALLY. Thank you.

The Chair now recognizes Mr. Cory for 5 minutes to testify.

STATEMENT OF JAY A. CORY, CEO AND PRESIDENT, PHOENIX RESCUE MISSION

Mr. CORY. Thank you, Chairwoman McSally and committee, for allowing me to be here to share today.

Arizona faces an epidemic of substance abuse that translates into staggering costs to our State. It is one of the leading causes of homelessness, poverty, crime, rising medical costs, incarcerations, repeat offenders, recidivism, child removal into State custody, and family deterioration.

I am going to dispense with statistics, as we have heard plenty.

The opioid crisis is a wake-up call. However, substance abuse, other addictions, and negative behavioral manifestations such as violence and abuse continue to rise as well. Society continues to increase its desire for instant gratification, self-medication, and escape.

The problem is greater than just availability of chemicals. Our society is declining spiritually. We have seen the breakdown of the family with more fatherless households and a growing number of those who cannot sustain themselves and afford the cost of living.

The problem does not operate in isolation. There is a large underserved population of men, women, and families facing poverty, homelessness, and trauma in Arizona, and especially in the Phoenix metropolitan area.

Poverty. There are over 1.1 million persons, or 16.4 percent of Arizona, below the poverty line.

Homelessness. There are more than 37,000 persons who experience homelessness in Arizona, and there may be as many as 8,900 homeless on any given night. In Maricopa County there were 22,000 experiencing homelessness, or 54 percent of the State's total, with more than 5,600 on any given night.

Lack of affordable housing. There is grossly insufficient affordable housing in Arizona, and often it is not safe and healthy. Many leave recovery programs or incarceration and go right back to use because they can't afford to live.

Recommended solutions. Phoenix Rescue Mission applauds the efforts to reduce supply and efforts toward prevention of substance abuse. Phoenix Rescue Mission also supports the efforts of medication-assisted treatments to reduce cravings for and effects of opiates.

There is an immediate, drastic need for increased capacity for cost-effective, comprehensive residential and non-residential programs that provide pathways out of poverty, homelessness, addiction, and other life-controlling problems. Most need more than just temporary relief or short-term programs and are unprepared for direct placement into housing. These programs should include a crisis component, crisis stabilization, get people out of situations that they are in, bring them to a safe place where they can be assessed and properly placed.

There needs to be a drastic increase in comprehensive recovery programs, both short- and long-term, "comprehensive" meaning case management services, academic assistance, English as a second language, vocational development, job placement, spiritual growth, and counseling.

Reentry. There needs to be expanded capacity for housing and support services for persons completing residential work.

Recommended solution. Work in partnership with faith-based providers. Example: Association of Gospel Rescue Missions. Phoenix Rescue Mission is a member of the Association of Gospel Rescue Missions. There are seven member missions in Arizona. Now in its 105th year, the Association is North America's oldest and largest network of independent crisis shelters and rehabilitation centers. Each year AGRM members serve more than 65 million meals, 24 million nights of lodging, 36,000 people find independent housing, and they assist about 45,000 people in finding employment, and 17,000 people from addiction recovery programs are placed into productive living.

Just a little experience, recent experience from the Phoenix Rescue Mission. The first step into admission into all residential programs is called RAP, which is a 7-day triage program. Statistics for the last 10 months, ending April 30, we admitted 542 unduplicated men. The top three presenting problems were homelessness, financial crisis, and substance abuse. The top disclosed drugs of choice for substance abusers were alcohol, stimulants, cannabis, and

opioids. Opiates were 38 percent. Three hundred and ninety-two, or 72 percent of the men were successfully placed in appropriate solution programming, with 254 or 47 percent being placed in our first phase recovery program. People are getting off the streets, and they are getting plugged into treatment programs.

On the women's side, we had 217 unduplicated women, the same basic breakdown of presenting problems, with a 40 percent opiate. So we are out on the streets.

A couple of anecdotal points. Because of our street teams that go out on the street, we have two vans out there every day. They are younger. Obviously, heroin is increasing as a drug of choice. It is less expensive. We are seeing that the results of our efforts to reduce prescription meds on the street is taking effect because they are becoming more expensive. However, people are turning to a cheaper alternative such as heroin.

Thank you for allowing me to share.

[The prepared statement of Mr. Cory follows:]

PREPARED STATEMENT OF JAY A. CORY

MAY 30, 2018

THE PROBLEM

Arizona faces an epidemic of substance abuse that translates into staggering costs to our State. Substance abuse is one of the leading causes of homelessness, poverty, crime, rising medical costs, incarcerations, repeat offenders, recidivism, child removal into State custody, and family deterioration.

According to AZ DHS website for the period 6/15/17–5/24/18, there were:

- 1,238 Suspected opioid-related deaths,
- 8,022 Suspected overdoses,
- 766 Neonatal Abstinence Syndrome,
- 5,262 Naloxone doses administered,
- 347,816 Opioid prescriptions dispensed last month.

The opioid crisis has been a wake-up call. However, substance abuse, other addictions, and negative behavioral manifestations such as violence and abuse continue to rise as well. Society continues to increase its desire for instant gratification, self-medication, and escape.

The problem is greater than just availability of chemicals. Our society is declining spiritually, we have seen the breakdown of the family unit with more fatherless households, and a growing number of those who cannot sustain themselves and afford the cost of living.

The problem does not operate in isolation. There is also a large underserved population of men, women, and families facing poverty, homelessness, and trauma in Arizona and especially in the Phoenix metropolitan area.

- *Poverty*.—PRM provides services in some of the most poverty-stricken areas of our community and Nation. Many lack the basics needed to sustain themselves and are often only one step away from homelessness. They are often unaware or unable to connect to services that may assist them. There are over 1,100,000 persons or 16.4 percent in AZ below poverty line ranking 43rd in the Nation. More efforts are needed to provide elevation through vocational development and education.
- *Homelessness*.—According to AZ DES 2017 report, more than 37,000 persons experienced homeless in AZ and there may be as many as 8,900 homeless on any given night. In Maricopa County there were over 22,000 experiencing homelessness or 54 percent of the State's total with more than 5,600 on any given night. Of those experiencing homelessness, 67 percent were single adults, 12 percent were adult members of families, and 21 percent were children in families. Causes include economic factors, substance abuse, mental health issues, and domestic violence.
- *Lack of Quality Affordable Housing*.—There is grossly insufficient affordable housing in Arizona and often it is not in a safe and healthy environment. Many leave recovery programs or incarceration and go right back into a war zone. Housing is the fundamental intervention that moves an individual or family

from homelessness to self-sufficiency. Without housing, all other intervention programs are less effective. There is a great need to provide healthy supportive housing communities.

RECOMMENDED SOLUTIONS

Phoenix Rescue Mission (PRM) applauds the efforts to reduce supply and efforts toward prevention of substance abuse.

PRM also supports the efforts of medication-assisted treatments to reduce cravings for and effects of Opioids (example—Vivitrol).

There is an immediate drastic need for increased capacity for cost-effective comprehensive residential and nonresidential programs that provide pathways out of poverty, homelessness, addiction, and other life-controlling problems. Most need more than just temporary relief or short-term programs and are unprepared for direct placement into housing. Their life-controlling problems are often complex and need comprehensive community and residential services. These programs should include:

- *Rescue—Crisis Response and Stabilization* to prevent further decline by meeting basic needs, providing stability, support, assessment, and guidance in developing and executing a solution plan. Motivated persons must have their immediate needs met or brought to a safe place so they can be properly assessed and placed into the right solution pathway.
- *Recovery from Life-Controlling Problems*—Comprehensive services to address the total person toward solutions and sustainability. Services such as case management, connection to services, academic assistance such as GED/High School Diploma, and English as a Second Language, vocational development and job placement, spiritual growth, counseling, life skill development, short- and long-term addiction recovery.
- *Re-Entry*—Expanded capacity for housing and support services for persons completing residential recovery programs, existing incarceration, and other populations so that they can continue forward momentum.

Work in partnership faith-based providers. Many do excellent work and receive little to no Federal funding. Remove barriers and provide equal opportunity for funding. An example:

- *AGRM—PRM* is a member of the Association of Gospel Rescue Missions. There are 7 member missions in Arizona. Now in its 105th year, AGRM is North America's oldest and largest network of independent crisis shelters and rehabilitation centers. AGRM has nearly 300 rescue mission members across North America. Each year AGRM members serve more than 65 million meals, provide more than 20 million nights of lodging, and help more than 36,000 people find independent housing, assist about 45,000 people in finding employment, bandage the wounds of thousands of abuse victims, and graduate nearly 17,000 people from addiction recovery programs into productive living. Every year, AGRM members use 300,000 volunteers and 10,000 full-time staff to serve.

PRM'S RECENT EXPERIENCE

Rescue-Assess-Place (RAP) Program.—Is the first step for admission into all PRM programs and is a maximum 7-day residential triage program for motivated adult men, women, and mothers with children under the age of 12 facing homelessness and/or seeking recovery from addiction or other life-controlling problems. PRM Rescue-Assess Place (RAP) Program statistics for last 10 months 7/1/17–4/30/18.

- PRM admitted 542 unduplicated men into RAP. The top 3 presenting problems disclosed were homelessness (513 or 95 percent), financial (434 or 80 percent), and substance abuse (337 or 62 percent). The top disclosed drugs of choice for substance abusers were alcohol, stimulants, cannabis, and opioids (38 percent). Note: 392 or 72 percent of men were successfully placed in an appropriate solution program with 254 or 47 percent being placed in PRM's Foundations (phase 1 recovery program).
- PRM admitted 217 unduplicated women into RAP. The top 3 presenting problems disclosed were substance abuse (170 or 78 percent), homelessness (103 or 47 percent), and financial (91 or 42 percent). The top disclosed drugs of choice for substance abusers were stimulants, alcohol, and opioids. (40 percent). Note: 177 or 82 percent of women were successfully placed in an appropriate solution program with 117 or 54 percent being placed in Foundations.

Street Outreach.—PRM's Street Outreach ministries go out in Hope Coach vans to engage unsheltered homeless individuals to rescue them off the streets and into appropriate solutions. Basic survival needs such as water and hygiene kits are provided. Street Outreach partners with law enforcement and first responders and

caseworkers to provide solutions to homeless individuals and the neighborhoods affected by homeless camping. PRM's street teams are trained and equipped in the use of Naloxone (Narcan). From 7/1/17–4/30/18 Street Outreach:

- Engaged over 650 individuals for attempted rescue.
- 95 were engaged off the street and transported off the street and connected to services.
- 25 percent of those rescued were admitted opioid abusers.
- 55 were admitted to PRM's RAP program.

Anecdotal observations from the street teams over the past few months:

- The three greatest segments of those on the streets are substance abusers, mentally ill, and service resistant. Particularly among the substance abusers there is a large number that are responsive to "hand-up" options when properly engaged and the timing is right.
- Heroin continues to be prevalent on the streets and is rapidly ascending as a drug of choice. It is available and less expensive than many other choices.
- There is a growing number of heroin addicts that started as result to addiction to pain medication. Many of these are relatively inexperienced in homelessness and are vulnerable.
- Pain medication is decreasing in supply and becoming more expensive. Heroin is a much less expensive option and more readily available.
- Many panhandlers are substance abusers with an increasing number addicted to heroin.

PRM has experienced success in working with clients in recovery from opioid addiction particularly in its long-term "Transformations" recovery program. Currently both the men's and women's RAP program are run by graduates each with over 5 years sobriety. Graduates are also in leadership positions with our Street Outreach and Foodbank operations. To see many of PRM's stories of success, please visit *www.phoenixrescuemission.org*.

PRM has current plans to expand its residential capacity for men's recovery by over 300 beds with anticipated construction beginning by the end of 2018.

Ms. MCSALLY. Thank you, Mr. Cory.

The Chair now recognizes Mr. Warner for 5 minutes to testify.

STATEMENT OF WAYNE WARNER, DEAN OF MEN, TEEN CHALLENGE CHRISTIAN LIFE RANCH

Mr. WARNER. Thank you, Congressman McSally and Ranking Member Grijalva. I want to thank the distinguished Members of the subcommittee for allowing us to come today. I also want to thank the current and past panels for all their efforts. It is an absolute honor to represent Teen Challenge of Arizona today as a graduate of the program.

Like Mr. Cory, I will also be dispensing with statistics and simply share my personal experience with addiction.

My name is Wayne Warner, and I am the dean of men at the Teen Challenge Christian Life Ranch in New River, Arizona. Miraculously, I am an ex-opioid addict that has had the pleasure of not only testifying today but also being alive after an extensive period of illicit drug use took me down a path of misery and discontent.

My story begins at 16 years old, when a conflict at school left me with the ring and pinky appendage of my left hand severed after a door was closed on them. I cite this experience not for the trauma or the pain, but the pain management I received for my injury. I was a 16-year-old handed narcotics to take when I "needed" them to manage the pain in my hand. I remember this experience vividly, and I still refer to this as the day I first felt OK with myself.

Although I so enjoyed this feeling, the thought of becoming a drug addict truly terrified me to my core. It would take a few years for my addiction to truly take over my life. After a seemingly slow graduation from marijuana to pills again and then eventually her-

oin, I found myself homeless, jobless, and nearly lifeless. I had been arrested several times, charged with felonies, and sent on my way time and time again. I was an angry, injured shell of a human being attempting to carry around the fragmented pieces of my life from rehab to rehab until I could get enough rest to find the energy to wake up and do it all over again.

Life at this point was meaningless and people were pointless. Love was an idea, abandoned and buried in the cemetery with my relationships with my family and friends. People would die around me and I felt like the lone sailor in the sea, waiting for the shark of addiction to come up and ambush me from beneath, but I was not afraid of him. I was afraid that I would have to wake up when the sun rose and the slow and painful torture of withdrawal would begin to set in once again.

I was arrested for the last time on October 28, 2012 after I stole a vehicle from the family member of a friend in order to pick up a bag of heroin with the last $20 I had to my name. As I spoke through the bars of the back window of the Peoria Police Tahoe, I recall giving my mother's name and her number to my friend and asking him to tell her that I was arrested once again and to please just leave me in jail this time.

Unbeknownst to me, on that very same day, two men from the Christian Life Ranch in New River, Arizona would knock on the door of a woman's house that desperately needed her son to get help. They gave their testimonies, prayed with her, and promised her they would pray for her son to get the help he needed. That woman's name is Tammy, and she is my mother.

I was sentenced, I served my time, and I was released. It was ordered that one of the conditions of my probation would be the completion of the Teen Challenge program. It was also made clear to me that in the State of Arizona I would then and always carry the legal label of "felon" indefinitely.

Over the following years a few major milestones would be achieved in my life. Teen Challenge and adult probation were completed. I committed to and completed an internship at The Ranch and was later hired on as a full-time employee.

This might sound like every other redemptive story you have heard, and you might be partially correct. There is one thing that makes me different, and that is the fact that I have had my immediate family and my Teen Challenge family behind me every step of the way. They never gave up, never put me down, and never stopped loving me.

I was baptized, affirmed, counseled, and unconditionally loved. I owe a debt of gratitude not only to both my family and my program but also to Jesus Christ, my personal Lord and savior. If it weren't for these relationships being so strong and dependable, I would not be where I am today. My life has now exponentially improved. I get to be part of a team of leaders that is spearheading the effort to discuss and resolve the real-life issues that people like me have dealt with and some of us have died because of. I am sought after for guidance, support, and even advice.

I will be celebrating 6 years of sobriety this October. I will be celebrating my 1-year anniversary with my wife Kendra this June,

and we will be celebrating the birth of our newborn baby boy in July.

It is through the program of Teen Challenge, programs like it, the people that work there, and the grace of God that I am able to speak in front of you today.

There is hope for the epidemic our country and our world is currently facing, and that hope is found in love.

Thank you, and God bless.

[The prepared statement of Mr. Warner follows:]

PREPARED STATEMENT OF WAYNE WARNER

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Although I so enjoyed this feeling, the thought of becoming a drug addict truly terrified me to my core; it would take a few years for my addiction to truly take over my life. After a seemingly slow graduation from marijuana, to pills again and then eventually heroin; I found myself homeless, jobless, and nearly lifeless. I had been arrested several times, charged with felonies and sent on my way again time after time. I was an angry, injured shell of a human being attempting to carry around the fragmented pieces of my life from rehab to rehab until I could get enough rest to find the energy to do it all over again. Life was meaningless and people were pointless. Love was an idea, abandoned and buried in the cemetery with my relationships with my family and friends. People would die around me and I felt like the lone sailor in the sea; waiting for the shark of addiction to come up and ambush me from beneath; but I wasn't afraid of him. I was afraid that I would have to wake up when the sun rose and the slow and painful torture of withdrawal would begin to set in once again.

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This might sound like every other redemptive story you've heard, and you might be partially correct. There is one thing that makes me different; that is the fact that I have had my immediate family and my Teen Challenge family behind me every step of the way. They never gave up, never put me down, and never stopped loving me. I was baptized, affirmed, counseled, and unconditionally loved. I owe a debt of gratitude, not only to both my family and my program; but also to Jesus Christ, my personal Lord and Savior. If it weren't for these relationships being so strong and dependable, I would not be where I am today. My life has now exponentially improved. I get to be part of a team of leaders that is spear-heading the effort to discuss and resolve the real-life issues that people like me have dealt with and some of us have died because of. I'm sought after for guidance, support, and even advice. I will be celebrating 6 years of sobriety this October. I will be celebrating my 1-year anniversary with my wife Kendra this June; and we will be celebrating the birth

of our newborn baby boy in July. It's through the program of Teen Challenge, the people that work there and the Grace of God that I am able to speak in front of you today. There is hope for the epidemic our country and our world is currently facing; and that hope is found in love

Thank you and God Bless.

Ms. MCSALLY. Thank you, Mr. Warner, for your courage to share your personal story with us. It is pretty powerful.

Mr. Schweikert needs to leave, so I am now going to recognize him first for questions.

Mr. SCHWEIKERT. Thank you for that.

Being raised by a woman who spent much of her later adult life in a 12-step program and then became a substance abuse counselor right down the street here, trying to recruit drug-addicted prostitutes off the street, you don't sometimes process the human tragedy substance abuse can be.

I have to leave in a moment, but I do have some questions.

Dr. Christ, just because it bothered me but also was optimistic, you made a comment that we have a 50 percent reduction in high-volume prescriptions for opioids.

Dr. CHRIST. Yes.

Mr. SCHWEIKERT. For the remaining 50 percent, how much of that is palliative, of the remaining 50 percent?

Dr. CHRIST. So that would be through our Controlled Substances Prescription Monitoring Program. What we are doing is the 90. A lot of it is going to be pain management.

Mr. SCHWEIKERT. That is actually where I am going. We have all had this issue in our lives, someone who is in hospice, for those things. In that case there is going to be pain management. My concern is 50 percent reduction is miraculous. What if that remaining 50 percent is still bad actors, and what if that is just what should be the baseline in our society? I know I am asking you to speculate, but you are bathing in the data.

Dr. CHRIST. Right. We can go back and look. That is a very interesting question. I don't know that I have the specifics because we would have to go back and match medical records.

Mr. SCHWEIKERT. It is hard, but that is actually one of the things I am after. If you are making an argument that opioids are different than other types of addictions in our society, that this gateway comes through our medical profession, so the demographics are different, the population looks different than often the youth and other types, but of our population, how many should be there? If it is only another 10 percent or so, we need to solve that other 40 percent. Am I making sense?

Dr. CHRIST. Absolutely.

Mr. SCHWEIKERT. What do we do as Federal policy makers? I am working on a technology piece that does a prior authorization. That is bipartisan. That will go through. But is it a technology solution? Is it a data solution? Is it a human solution? Help us find one.

With that, Madam Chairman, I yield back. Forgive me, I must leave.

Ms. MCSALLY. Absolutely.

Dr. Christ, do you want to reply at all?

Dr. CHRIST. I would say it is probably all three. So it is probably going to be a technology solution, a data solution, and a human solution. But out of concern for those who do need it for hospice or

end-of-life or palliative care, that has been exempted and they are not required to stick to the dose restrictions.

Mr. SCHWEIKERT. We need to understand how much of our population prescription usage is that population, and then the rest we need to analyze and understand.

Dr. CHRIST. Absolutely.

Mr. SCHWEIKERT. Thank you.

Ms. MCSALLY. The Congressman yields back.

The Chair now recognizes the acting Ranking Member, Mr. Grijalva, for 5 minutes.

Mr. GRIJALVA. Thank you very much.

First of all, Mr. Warner, thank you for sharing with us and everybody. Your journey, as difficult as it was, it was a light, and we appreciate you taking the time to be with us today and sharing that.

Dr. Christ, at the beginning of my opening statement I said I wish somebody from the pharmaceutical industry was here, and the reason is that there is no question in terms of linkage that much of what we are dealing with right now with this opioid crisis began with the prescription painkillers that became part and parcel, and now you see an increase in heroin and fentanyl as substitutes for that.

One of the reasons it is a question is that Naloxone, which is a life-saving overdose drug was, interestingly enough, in 2014 it was $288 for an injection. Right now it is over $2,000 for an injection. I think somebody recognized a market, and when local communities, particularly law enforcement and public health officials, are attempting to get hold of this as a life-saving opportunity to have out there, the price has been raised. So I think they need to be part of this.

If you had $76 billion to spend on the opioid crisis Nation-wide, where would you prioritize the money? What would be your first priority?

Dr. CHRIST. I think going back to Ms. Moak's response, I think this has to be a two-pronged approach. I think you need to provide access to treatment and improve the ability for patients that are currently suffering from opioid use disorder to have access to the treatment they need. But I think in order to respond and deal with this in the future, you really have to have targeted prevention and harm reduction efforts.

Mr. GRIJALVA. Thank you. One of the studies showed that since 2000 the cost of the opioid crisis has been $1 trillion, and that in the next few years it could be $500 billion. So I appreciate your answer, because I think that is one of the focuses that we need to have when we talk about this.

Mr. Cory, in your experience, in dealing with the fine work you do, particularly in outreach and retrieving people to try to provide support, I am glad you brought up the issue of poverty and other things that are contributing factors that we don't talk about enough.

Do you believe that the majority of opiate users started out on heroin and fentanyl?

Mr. CORY. We are dealing with people that are actually right off the streets, people that are coming into our RAP unit, which is

more like a social detox. I think that there has been a heroin problem for a very long time, there has been a substance abuse problem for a very long time. I would say that there has been an adjustment in the population. We are seeing a new element enter into the population. Again, we are focused sort-of at the bottom of the safety net in that they are younger people that, because of prescription med addiction, fell into heroin addiction. So they are younger. There are a lot more females on the street than there used to be.

I don't know if I am answering your question.

Mr. GRIJALVA. You did.

Ms. Moak, in the limited time that I have, your testimony I think did a great job of explaining why prevention is so important and the various techniques that can be employed to fight substance abuse in all forms and dealing with the opioid crisis in this hearing.

Where does border security funding fall as a prevention strategy to end the demand for drugs in this country, and how do we reconcile the proposed cuts to nutrition, Medicare, Medicaid, community development in terms of the efforts at prevention?

Ms. MOAK. I think that is a great question. Certainly, that is prevention, not having these drugs come across our borders. But for me, I like scaling what is most cost-effective and makes the most sense, and that is not seeing our youth get started using any type of drug. We have this crisis right now. We have had others before. We will have others after this.

So working in the schools and scaling, quite frankly, behavioral health right now in our school setting is a great use of funds.

Mr. GRIJALVA. Dr. Segay and others, my time is up, but I have written questions, and I appreciate Dr. Segay bringing a perspective that sometimes at these hearings is not heard often enough.

Thank you.

Ms. MCSALLY. The gentleman yields back.

I now yield to myself in place of Mr. Schweikert.

Mr. Warner, thanks for sharing your personal story, and congratulations on the coming birth of your daughter. It is exciting and hopeful, and I think you know that some decisions you made and what may have been intended for evil, God has used for good in your redemptive path. So I am really proud of your courage to be able to share that story and invest in others.

If you could talk to your 16-year-old self and look back at that moment in time—you obviously had an injury, you were in pain—what would you advise be done differently both within your choices and those around you, whether it is the doctor or others in your life, friends and family, in order to have you go on a different path?

Mr. WARNER. I am so glad that I have an opportunity to speak more than just my testimony, because I have a lot of opinions on this stuff, and so I just appreciate just this moment in time.

First off, as Ms. Moak was speaking about, preventive measures have to be taken. We actually do a segment called Stay Sharp where we go into middle schools, high schools, and elementary schools, and we give our testimonies to adolescent children, and the teachers come up to us after and say, hey, can you stay back and talk to this one person that I really feel needs help? What that tells me is two things: This person really doesn't have anybody to talk

to at home, and they don't have anybody to talk to at school. The teacher doesn't know what to do until we just show up out of the blue and they think, oh, I am so happy you guys are here, now this person can speak. But we have a limited amount of time.

So having a representative from some type of organization that is in the school that has a personal relationship with these adolescents would be monumental in terms of being able to sense where a person is and how they can help, No. 1; No. 2, $76 billion, if we had that—I mean, just being able to fund that type of thing inside of public schools and private schools, not only are you going to see the addictions start to drop because we are heading it off, we are nipping it in the bud before it can even get to this epidemic, but then also supply is meeting demand right now, and as long as you have demand, you will get supply.

I don't want to diminish the task forces that we have heard from today whatsoever, but the fact is that all of the drugs that they have taken off the streets, I did not have an issue finding them. I am letting you know that right now. It wasn't like, hey, guess what? There was a big bust, we are not going to get high today, unfortunately. I hate to be crass, but that is the reality. It was never an impact.

So that was what I would have liked to have known, that there was somebody there that understood me and that cared about me. Thank you for your question.

Ms. MCSALLY. Thank you, Mr. Warner.

As we have seen from this panel, we have now two faith-based organizations and not $1 of Government funding. They are changing lives and impacting lives, and a non-profit that is also involved and engaged. Not every school needs to have the Teen Challenge visitors. Not every school is going to be able to have notMYkid. But the complementary nature of all of what you are doing, combined with an appropriate Government role, I think is really what has come out of this panel a lot, right? It has to be all of the above.

Is there any sort of collaboration or coordination among the non-profits with the Government, Dr. Christ, related to, hey, we are focused over here, but there is really an issue in this geographic area, or we need to be doing more on the reservations and cooperating and getting some non-profits coming in there? Is there some way for there to be that collaboration in order to address this and identify where the needs are, an all-of-the-above strategy?

Dr. CHRIST. I think that is a fantastic question. Through the Governor's Council we did try to bring together stakeholders, whether they were patients, associations, faith-based, non-profits. But I think one of the biggest assets that the Governor has is the Governor's Office of Youth, Faith, and Family, because they do a fantastic job convening those organizations and getting funding to them.

Ms. MCSALLY. Ms. Moak, and then I want to ask Dr. Segay.

Ms. MOAK. In fact, since I left the Governor's Office, that is exactly what I am working on. We know that Federal/State funds will never be enough to solve this. One example, one small example, I am currently working with Blue Cross Blue Shield, and their bottom line was we want to fund what you are already doing, we don't want to start something from scratch.

So we are taking a look, again, at all the initiatives we already have that have data and bringing in more private sector, like Blue Cross Blue Shield, to scale.

Ms. MCSALLY. Dr. Segay, Indian Health Services is, obviously, critical on the reservation. Are there other non-profits or others that would be culturally acceptable to be able to partner with and help on the reservation for those who are struggling with addiction? Are they present there?

Dr. SEGAY. Thank you for your question, Madam Chair. The reality there on Navajo is that we have been trying to pretty much demonstrate the effectiveness of our method of treatment with traditional services, and it has been hard. We don't have an evidence base as far as what ceremonies are effective or disciplined. We have what is effective-based. So right now, all of our ceremonies are traditional methods with our traditional practitioners, and are not reimbursable. So it is really complicated to say here is an evidence-based ceremony that needs to be reimbursed.

In reality, we have been going to CMS and letting them know that this needs to be reimbursable, pretty much. I mean, it just connects to everything. So collaboration is happening among our Tribal programs, our Public Law 93–638 facilities, and IHS as far as their satellite, and then the Tribal programs, keeping in mind that Navajo is 27,000 square miles, with 350 enrolled members. Thank you.

Ms. MCSALLY. Thanks.

I am totally out of time. Mr. Cory, I wanted to ask you a question, but I want to respect everyone's time.

The Chair now recognizes Mr. Gallego for 5 minutes.

Mr. GALLEGO. Thank you, Madam Chair.

Ms. Moak, I actually missed it, but I was looking through your testimony. You mentioned a program that was run out of U of A that ran out of funds. Can you refresh my memory on that?

Ms. MOAK. Yes, sir. It was actually a program that was evaluated by ASU. The program was a prevention program where we designed the curriculum, scaled it for the past 2 years into 7th grade, has great data, was loved by students, parents, and faculty, very affordable and easy to scale, and literally we don't have funding for it this coming year.

Mr. GALLEGO. So why don't you have funding for it this coming year?

Ms. MOAK. The grants change from year to year.

Mr. GALLEGO. The grants are coming from the Federal Government or the State government?

Ms. MOAK. Yes, sir. A Federal grant.

Mr. GALLEGO. Which department is it?

Ms. MOAK. I apologize, I am blanking on that right now. But the grant is not available to us next year.

Mr. GALLEGO. OK. If you could provide that information tomorrow, I would greatly appreciate it.

Ms. MOAK. Yes, sir, I will.

Mr. GALLEGO. Director Christ, you heard my comments earlier to Governor Ducey. As someone who is very knowledgeable on Medicaid, and someone like me who actually really is proud of AHCCCS here in Arizona, I am concerned that there is a missing

link here among our Arizona government through the Governor, that they don't actually quite understand how important Medicaid is to preventing both opioid deaths and addiction.

Could you just give us some examples of how helpful Medicaid expansion can be in terms of dealing with our opioid epidemic?

Dr. CHRIST. Given the 5-minute limitation, I think that that is a——

Mr. GALLEGO. I will give you 2 minutes of the 5 minutes.

Dr. CHRIST. OK. I didn't get to highlight how engaged AHCCCS and the Medicaid program have been in Arizona's response. We have partnered with Director Betlock and his team. They are responsible for administering the $24 million State-targeted response grant that came through SAMHSA last year. They are actually integrating that into the Medicaid program so that our substance abuse patients and those who are suffering from opioid use disorder get the same services, and especially for that $10 million funding that they found for the uninsured and underinsured. That will be partnered with our AHCCCS program.

So we are using Medicaid in Arizona as the base for expanding our medication-assisted treatment and our treatment options.

Mr. GALLEGO. To switch gears, in terms of FQHCs—I am really bad with acronyms—Federally Qualified Health Clinics, there has been a severe cut in terms of funding for FQHCs, which deals with a lot of that population. Do you see it as a good investment in terms of putting money back into FQHCs in terms of trying to curb the human costs of the opioid epidemic?

Dr. CHRIST. Absolutely. I think that, luckily in Arizona, we have a very strong partnership with our FQHCs and their association, and so we are utilizing them. They are a perfect resource. They are State-wide. They provide whole-person integrated care. They are a great partner for our opioid use disorder patients.

Mr. GALLEGO. Great. Thank you, Dr. Christ.

Dr. Segay, as you know, the opioid epidemic's impact on Indian Country has been quite profound. Fully 10 percent of Native children have used opioids for non-medical purposes, which is double the rate of Anglo children. In addition, Native women who are pregnant are nearly 9 times more likely to be diagnosed with opioid dependency or abuse compared to the general population.

This epidemic has also strained Tribal governments that already are facing significant challenges in general.

In the face of so much suffering, what can we do as the Federal Government to step in? I particularly ask this because I am going to be the incoming Chairman of the Indian Affairs next year and would like to make sure that I am ready and prepared to be helping out Indian Country.

Dr. SEGAY. Thank you for that. Well, on Navajo, we pretty much always try to educate our leaders. So we always make the request to our leaders in Washington at the Federal level that they come visit Navajo so that they can understand and see how our health care delivery system is set up.

So, for example, in some areas it is 100 miles to the nearest facility, and we don't have helicopter service, or even our safety response is like a 2- or 3-hour response. So that is where there is the

golden hour, and that is where we lose a lot of our people, especially if there is an opioid overdose.

Mr. GALLEGO. Not to take too much time, but this is certainly a problem dealing with East Coast politicians. They don't understand the concept of a Native American reservation, because over there the land is the size of a stamp, and tribal lands are the size of States compared to the East Coast. So I do agree that we need to have that education for them.

Dr. SEGAY. Yes, and more funding for AHCCCS. Thank you.

Mr. GALLEGO. One hundred percent. I like how you got that in under the wire.

[Laughter.]

Mr. GALLEGO. Thank you so much. Thank you for all your testimonies.

Ms. MCSALLY. The gentleman's time has expired.

The Chair now recognizes Ms. Lesko for 5 minutes.

Ms. LESKO. Thank you, Madam Chair.

Thank you, panel, for everything that you do for our community.

What has become clear to me in this whole hearing today is we need a multi-faceted approach, which we are taking, to solve this opioid crisis and drug abuse crisis, and I really thank you, Mr. Cory, for the work that you do in the community, and Mr. Warner for sharing your story. I hope you can continue sharing your story. It is very inspirational, very touching. What a success story. Thanks for sharing it.

I have a really kind-of common-sense basic question, not about statistics or anything like that. This is something that comes up, and I, quite frankly, want to know the answer and see what your insight is. That is, I see a huge increase in panhandlers on the streets. My district includes Sun City, and I am starting to see panhandlers on the streets in Sun City on Grand Avenue, which hadn't happened before. The number of homeless, too, really seems to be increasing.

So my first question is do you think that the increase in panhandlers is due to drug addiction? Are they trying to get money for drug addiction? My follow-up question is, as an individual who is compassionate, should I give them money or should I not? Maybe all of you can answer it, but I have a feeling that Mr. Cory and Mr. Warner probably are the best ones to answer those questions.

Mr. CORY. This is a Rescue referral card so we will come pick you up, we will give you free food, we will take care of you. So do not give them money is my counsel. I have a bunch of them with me, be happy to share them with you.

So, yes, there is an increase in panhandling, there is an increase in homelessness. You see it West Coast. What I see on the West Coast really scares me. It is not in our statistics yet, I don't believe, but there are people who are in Phoenix that actually came from San Diego and different places now. It is a mess over there. Addiction is 70 percent, in my opinion. That is because it is complicated with dual diagnosis, but certainly it is 70 percent substance abuse on the streets. That is my opinion. People will disagree with that.

I have many clients that are successful coming up through our program that were panhandlers for years. It is a good business. One individual I will refer to in Scottsdale got up in the morning

from his camp, got on public transportation, went to a spot and worked long enough to achieve a target dollar amount so he could get his fix and some food, and he went and got high until the next day, and he repeated it all over.

So panhandling is a good business. I am not saying it is all that way for everybody. We actually have some efforts that are in motion. We are launching soon a homeless-to-work program that will actually be targeted at giving panhandlers the opportunity to work for the day. But, yes, I think it is very much related to substance abuse.

Mr. WARNER. Yes. So, Phoenix Rescue Mission, this isn't a secret. This is something that they all know about. I want to say "all." I want to be very careful with that. The majority of people that are looking for help know about Phoenix Rescue Mission. They know about Teen Challenge. They know about these other organizations that want to help them. What you are seeing is somebody who is more than likely avoiding the help in order to do what they want to do.

My advice as a compassionate person, and the practice that my wife and I have employed in our relationship is if we run into somebody who seems as if they are in need, we ask them what their specific need is, and we either take them to go and get it or we get that thing for them and bring it to them. We don't give them currency. We don't give them things like that because if they have a specific need, we will take care of that. If you need gas in your car, we will go get you gas. If you need a meal, we will get you a meal. But in terms of just cold, hard cash, it is not necessary, in my opinion.

Ms. LESKO. I yield back.

Ms. MCSALLY. All right. Well, I want to thank the witnesses for their valuable testimony, and Members for their questions.

Members of the committee may have some additional questions for the witnesses. I know we didn't get into all the solutions, and I am grateful for your time and your passion on this issue. If we have other questions, we will ask them in writing, and we would ask if you could respond to them in writing.

Pursuant to Committee Rule VII(D), the hearing record will be held open for 10 days.

Without objection, the committee stands adjourned.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS FROM HONORABLE KRISTEN SINEMA FOR DOUGLAS A. DUCEY

Question 1a. An important part of addressing the opioid epidemic is reducing overprescribing and preventing doctor shopping. The PASS Act, which I have introduced with support from both parties in Congress, would require Medicare to notify outlier prescribers—doctors prescribing outside of established medical guidelines—that they are potentially overprescribing. Do you believe this will be beneficial to Arizonans efforts to reduce overprescribing?

Question 1b. What other actions would you recommend Congress take to support Arizona's efforts?

Answer. The opioid epidemic is a complex problem and there is no silver bullet to solve it. We have taken action at the State level in Arizona, but we welcome Federal action. The PASS act aims to prevent opioid overuse by providing annual notification to outlier prescribers of opioids compared to other prescribers in their specialty and geographic level. I strongly support this. This information will help doctors have a full picture of how their prescribing habits compare to their peers. While we have taken similar action on a State level, this is very important in the Medicare space given the July 2017 report by the Health and Human Services OIG report on high prescribing levels and potential doctor shopping in the program.

In addition to the PASS Act, there are several other steps the Federal Government can take to address the epidemic. One of the greatest barriers Arizona faces is the prohibition of Medicaid reimbursement for inpatient stays longer than 15 days. This Institute of Mental Disease (IMD) exclusion impacts approximately 24 facilities and 1,700 individuals throughout Arizona. The IMD exclusion prevents Arizonans from getting effective inpatient treatment they need to break their addiction.

With a Nation-wide shortage of inpatient beds, health care professionals, and treatment programs, this Federal restriction should be removed for all States, most critically for substance use disorder, immediately. Congress should amend the IMD exclusion to ensure that those in need of treatment are able to access it.

Another critical barrier is the current Medicaid rules restricting the coverage of Medication-assisted Treatment (MAT) programs for individuals who are in State or county correctional institutions. In 2017, the Arizona Department of Corrections reported that 77 percent of the 42,184 inmates assessed at intake had histories of significant substance abuse. Of those identified only 732 were enrolled into an addiction treatment program. We must do all we can to help individuals who are incarcerated overcome their addictions, including providing evidence-based MAT therapy, in order to reduce recidivism, provide people with a second chance, and become productive Arizona citizens. Indeed, these rules are contributing to a cycle of crime, costly incarceration, and a return to crime and prison because of addiction. These rules should be suspended and reevaluated to get effective treatment to those in State or county correctional facilities.

A significant contributor to the over-prescribing of opioid medication is the Centers for Medicare and Medicaid Services (CMS) Hospital Consumer Assessment of Healthcare and Providers and Systems (HCHAP) still utilizes a pain satisfaction score in its overall hospital ratings which does not align with the current efforts to reduce opioid use. This score has already been removed from the HCHAP reimbursement formula but this initial assessment score causes Arizona to rank below the National average with patients who report that their pain was "always well-controlled." The HCHAP should eliminate this scale from the survey to further enhance efforts to reduce the number of opioids being prescribed. We know that keeping people from getting addicted is the one sure way to reduce overdose and death, and eliminating this scale from the survey will help empower health care providers to make evidence-based decisions.

While Arizona leads the Nation in gathering real-time data on this crisis, a significant Federal barrier to understanding the scope of the epidemic are Federal reg-

ulations regarding reporting restrictions from certain facilities. Currently CFR 42, Chapter I, Subchapter A, Part 2 prohibits facilities from sharing substance abuse use disorder data which is a hindrance to comprehensive health care and surveillance program in our State. These privacy protections were certainly well-intentioned, but are impeding turning the tide on the opioid epidemic. The reporting restrictions should be removed and a requirement of Federal facilities to meet HIPPA requirements should be instituted.

Last, the presence of Federally-controlled health care facilities, with no State oversight or State reporting requirements presents multiple challenges for Arizona. First, we request that Federal health care facilities maintain State licensure. Currently, Federal health care facilities do not meet the same requirements as other health care facilities in our State. This divide creates confusion for our citizens, and allows a disparate level of care to be delivered to our veterans and members of our Indian Tribes. Arizona wants to ensure that members of our community receive quality care regardless ofthe facility, be it Federal, State, or privately-owned.

We would also request a requirement for Federal health care providers to input dispensing data into the States' prescription drug monitoring programs. Without Federal participation in the States' drug monitoring program, there is an increased risk for over prescribing and dispensing. This would also include participating in State-based communicable and non-communicable disease reporting, allowing Arizona's health care professionals access to information about an at-risk population and the potential impact to their communities.

Although these requests are spread across the full spectrum of Federal health care agencies, a unified and cooperative approach from local, State, and Federal health care providers is the only way that we can have an immediate and sustainable impact to this ever-growing crisis affecting not only Arizona but our country as a whole.

Question 2. Here in Arizona, the Sinaloa drug cartel and other transnational criminal organizations continue to bring heroin and methamphetamine into our State, in addition to other crime. In March of this year, the House passed legislation I co-introduced to crack down on international criminal gangs that threaten our safety. Our bill requires the administration to develop and execute a strategy that cuts off funding and other resources for organizations like Sinaloa. As a border State, what more can we do to enable State and Federal law enforcement to work together to combat the illicit financing of transnational criminal organizations, like those smuggling opioids and synthetic opioids into our State?

Answer. In order to effectively disrupt and dismantle transnational criminal organizations operating in our State, we must seize their illegal drugs and prosecute the criminals responsible for trafficking those drugs. The best way to counter their illicit financing is to destroy their profits. Although these organizations have been transitioning to more modern means of currency, the bottom line is that we must prevent their drugs from coming into the country, then we can put them out of business. This can be accomplished with increased interdiction operations in Arizona.

The best way for Congress to help us accomplish this goal is to provide State and local law enforcement agencies the resources they need to counter the drug cartels. Arizona is proud of our Department of Public Safety, Sheriffs, and Police Chiefs, and we know they could be of greater assistance to the Federal Government on the front lines of this problem, if they were to receive more funding. Through our Border Strike Force, Arizona has proven our commitment and capabilities to counter these criminal organizations, but so much more could be accomplished with more Federal resources. As the Federal Government faces many challenges hiring and retaining the workforce they need within the Department of Homeland Security, State and local agencies can be major contributors and a force-multiplier for these efforts.

Additionally, more U.S. attorneys are needed to prosecute drug traffickers. Increased funding to the Department of Justice for more prosecutors would help ensure that all of these criminals are brought to justice.

QUESTIONS FROM HONORABLE RAUL GRIJALVA FOR GUADALUPE RAMIREZ

Question 1a. CBP has relied on temporary duty assignments to meet regional staffing demands in recent fiscal years. How many officers have you needed to bring in from other parts of the country to staff the Tucson port of entry over the past year?

Answer. For fiscal year 2018 to date, a total of 300 officers have been temporarily assigned to the Tucson Field Office to assist with staffing demands at the various ports of entry. This assignment has been completed quarterly. Each quarter, a total of 100 officers are assigned to the Tucson Field Office.

Question 1b. How many more do you anticipate needing through the rest of the fiscal year?

Answer. Seventy-five CBP officers were temporarily assigned to the Tucson Field Office for the fourth quarter of fiscal year 2018.

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