U.S. Department of Justice
Questions for the Record
Committee on the Judiciary
United States Senate
Hearing on "Attacking America's Epidemic of Heroin and Prescription Drug Abuse"
January 27, 2016

Questions for the Record posed by Chairman Charles E. Grassley

1. **According to reports from law enforcement, increased illegal manufacturing of fentanyl has contributed to what the Centers for Disease Control and Prevention report says is a sharp increase in deaths involving synthetic opioids in 2014. What is the role of fentanyl in the heroin abuse crisis? What is the DEA doing to address the role of fentanyl and are there any steps Congress can take on fentanyl that would help?**

Response:

The Drug Enforcement Administration (DEA) has dedicated significant efforts to combat the use of heroin and illicit fentanyl. Because prescription opioids have a similar effect as heroin, they present an intrinsic abuse and addiction liability, particularly if used for non-medical purposes.[1] DEA seizure and intelligence information indicates that fentanyl is used as a substitute heroin by traffickers or as a heroin additive to intensify the opioid effects. As a result, users may be unwittingly using fentanyl. Additionally, law enforcement is increasingly observing fentanyl being illicitly manufactured and disguised as licit opioids such as oxycodone and then sold to unknowing users. Heroin users and people who misuse controlled prescription drugs (CPD) may then purchase what they believe to be heroin or an opioid CPD and experience severe consequences, including overdose and death. Traffickers utilize tableting machines to press fentanyl into pill form to mimic legitimate CPDs, such as oxycodone; the counterfeit pills bear the same markings as the legitimate CPDs and are often marketed to unsuspecting users.

DEA believes traffickers began utilizing fentanyl in addition to heroin as a result of high profit margins, ease of production, and no need for reliance on opium cultivation. In 2014, there was a 62 percent increase of heroin production in Mexico. Therefore, DEA believes the shift to fentanyl use is not due to a shortage of heroin. In order to address the fentanyl issue, DEA is currently monitoring the shipments of fentanyl and fentanyl analogue precursor chemicals as well as the emergence of other synthetic opioids. DEA is identifying and utilizing its emergency and regular scheduling authority to schedule fentanyl analogues as they emerge. DEA strictly regulates the import and export of List I chemicals, which includes those related to fentanyl and its analogues. DEA actively works with the United Nations Office on Drugs and Crime, the International Narcotics Control Board, and partner countries to develop information sharing

[1] National Institute on Drug Abuse (NIDA) testimony at a May 14, 2014, hearing before the United States Senate Caucus on International Narcotics Control, titled, America's Addiction to Opioids: Heroin and Prescription Drug Abuse.

procedures to better control precursor chemicals through combined task force projects. The aim of DEA's ongoing enforcement measures are to be aggressive in combating heroin and fentanyl trafficking with our national and international partners. DEA supports legislation in this area, as legislatively scheduling fentanyl analogues in Schedule I would provide immediate relief to the threat posed by these dangerous substances.

Questions for the Record posed by Senator Richard Blumenthal

2. **Shouldn't we have a national requirement for all doctors who apply to the DEA to prescribe these highly addictive drugs be required to take some classes about proper pain management and spotting addiction?**

Response:

On April 19, 2011, the Administration announced its response to the prescription drug abuse epidemic within the Prescription Drug Abuse Prevention Plan (the Plan), titled "Epidemic: Responding to America's Prescription Drug Abuse Crisis, which expands upon the National Drug Control Strategy." The Plan focused action upon four major areas: education, tracking and monitoring, proper disposal, and enforcement. Under the education focus area, the Plan called upon the Office of National Drug Control Policy (ONDCP), the Food and Drug Administration (FDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and DEA to work with Congress to amend the federal law to require practitioners who request a DEA registration to prescribe CPDs be trained on responsible opioid prescribing practices as a precondition of registration. The training would include assessing and addressing signs of misuse or opioid use disorder in patients.

The appropriate use of prescription drugs – including opiate drugs for indications such as pain management – is a necessary component of medical care to address the therapeutic needs of Americans. However, prescription drugs can pose serious risks and can cause serious negative consequences for individuals, families, and communities.

DEA continues to work with ONDCP, FDA, SAMHSA, and Congress to require prescriber education regarding the appropriate uses, as well as the potential risks, of prescription drugs. Prescriber education is critical in national efforts to reduce prescription opiate abuse. DEA supports effective prescriber education, on a continuing basis, on prescription opiates to help reduce inappropriate prescribing, misuse, and non-medical use of such medications. Other federal efforts include the recently published "CDC Guidelines for Prescribing Opioids for Chronic Pain."[2] The twelve recommendations contained in the guidelines are grouped into three categories: determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and, assessing risk and addressing harms of opioid use.

3. **While I applaud the DEA and ONDCP efforts to safely remove millions of pounds of expired and unneeded prescription drugs through the National Drug Take-Back Days, I wonder if allowing prescribers and pharmacists to partially fill prescriptions for opioid painkillers would also decrease the amount of prescription opioids from being diverted?**

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[2] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

Response:

DEA acknowledges and shares your concerns about reducing the availability of unused prescription drugs in the medicine cabinets of Americans and appreciates the importance of the issue you raised. Since 2010, DEA has held its National Drug "Take Back" Initiative (NTBI) to provide a convenient and safe option to dispose of unused, expired and/or unwanted prescription drugs. DEA's most recent NTBI was held on April 30, 2016. The twelfth NTBI is currently scheduled for October 22, 2016. As a result of all eleven National Take Back Days, DEA, in conjunction with its state, local, and tribal law enforcement partners, has removed a total of 3,235 tons of medications from circulation.

DEA worked extensively with the House Energy and Commerce Committee to provide technical assistance on H.R. 4599, Reducing Unused Medications Act of 2016. This bill was passed by the House of Representatives on May 11, 2016. As you know, on May 12, 2016 this bill was referred to the Senate Health, Education, Labor, and Pensions Committee as part of S. 524, the Comprehensive Addiction and Recovery Act of 2016, a bill package to combat opioid abuse. S. 524 was signed into law on July 22, 2016 (PL-114-198). This bill amends Section 309 of the Controlled Substances Act (CSA) to permit partial fills of Schedule II controlled substances per practitioner or ultimate user request, up to 30 days from the date of the original prescription. Prior to S. 524 being signed into law, partial fills were authorized for Schedule II controlled substances only in limited circumstances as set forth in 21 C.F.R. § 1306.13(a). (It should be noted that partial fills are already authorized for Schedules III-V under 21 C.F.R. § 1306.23). DEA supports the overall goal of these provisions in S. 524, which is to reduce the amount of CPDs dispensed to patients if they so desire, in an effort to keep unwanted and/or excessive CPDs out of the medicine cabinets of ultimate users. DEA appreciates the opportunity to work with Congress to address the prescription drug epidemic that is currently plaguing our nation. DEA will diligently work to promulgate regulations implementing the statute.

Questions for the Record posed by Senator Dianne Feinstein

4. **Prescription limits – Understanding that it is critical to maintain legitimate patient access to needed medications, do you believe it would help reduce overprescribing and unused or unwanted medications by limiting the number of prescriptions for Schedule II opioids that a prescriber can write?**

Response:

Although DEA is the agency responsible for administering the CSA, DEA does not act as the federal equivalent of a state medical board overseeing the general practice of medicine and lacks the authority to issue guidelines that constitute advice relating to the general practice of medicine.

DEA has consistently supported the prescribing and dispensing of CPDs for the legitimate treatment of pain within acceptable medical standards. This is outlined in the statement of policy DEA published in the Federal Register on September 6, 2006, titled, *Dispensing Controlled Substances for the Treatment of Pain*. This statement of policy is available on the DEA Office of Diversion Control website at www.DEAdiversion.usdoj.gov.

Under federal law and regulation, "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription." 21 C.F.R. § 1306.04(a).

There is information available for physicians prescribing opioids for the treatment of chronic pain at the Federation of State Medical Boards website: www.fsmb.org. There are two documents on this website which might be of service with respect to this issue: "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain," July 2013; and, "Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office," April 2013.

Federal efforts to provide important educational information to prescribers include the recently published "CDC Guidelines for Prescribing Opioids for Chronic Pain."[3] The twelve recommendations contained in the guidelines are grouped into three categories: determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and, assessing risk and addressing harms of opioid use.

The CSA and its implementing regulations contain no specific limit on the number of days' worth of a Schedule II controlled substance that a practitioner may prescribe on a single prescription. However, please be aware that some states do impose specific limits on the amount of a Schedule II controlled substance that may be prescribed on a single prescription. 21 C.F.R.

[3] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

§ 1306.04 requires that all controlled substance prescriptions be issued for a legitimate medical purpose in the usual course of professional practice.

The Final Rule published by DEA in the Federal Register on November 19, 2007, titled *Issuance of Multiple Prescriptions for Schedule II Controlled Substances* amended DEA's regulations to allow practitioners to provide individual patients with multiple prescriptions, to be filled sequentially, for the same Schedule II controlled substance. Such multiple prescriptions have the combined effect of allowing a patient to receive, over time, up to a 90-day supply of that controlled substance. This does not set a quantity limit, only a dispensing limit. The individual practitioner provides written instruction on each prescription (other than the first prescription, if the prescribing practitioner intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription. 21 C.F.R. § 1306.12.

Sources of Prescription Opioids

5. **What are the primary sources of the opioid painkillers your agency sees being abused? Does this vary by region or population? Are these drugs coming from doctors who unintentionally overprescribe, rogue actors operating pill mills, street level drug dealers, or another source?**

Response:

The primary CPDs used to treat pain are oxycodone and hydrocodone. Oxycodone is more commonly diverted than hydrocodone in the northeastern part of the United States. These CPDs are commonly abused throughout the United States and are often obtained through fraudulent prescriptions and pseudo patients. Pseudo patients obtain illegitimate prescriptions by providing misleading statements regarding pain to medical doctors or work in concert with medical doctors who write illegitimate prescriptions. Pseudo patients provide their CPDs to street-level drug dealers for distribution. Additionally, unused CPDs in medicine cabinets play a significant role in diverted CPDs.

6. **From a law enforcement perspective, what are the best strategies to curtail the supply of these abused prescription opioids? What can be done differently?**

Response:

DEA continues to investigate, disrupt, and dismantle drug trafficking organizations responsible for the diversion of opioid CPDs. Additionally, DEA is continuing to work closely with local and state law enforcement agencies and medical and pharmacy boards to identify and address the diversion of all CPDs. DEA is also expanding its outreach effort to local civic and community groups. DEA understands that we cannot simply arrest our way out of this problem, but instead, continue to educate youth and others about dangers of opioid CPDs. The opioid epidemic is inextricably linked to the heroin epidemic. The best strategies to deal with this problem need to confront it comprehensively, focusing on both heroin and opioid CPDs.

In order to help cities dealing with the heroin and prescription drug abuse epidemic and its associated violent crime, DEA has developed the 360 Strategy - a comprehensive law enforcement and prevention plan. DEA 360 involves: coordinated law enforcement operations targeting all levels of Drug Trafficking Organizations and violent gangs supplying drugs to our neighborhoods; engaging drug manufacturers, wholesalers, practitioners, and pharmacists to increase awareness of the opioid epidemic and encourage responsible prescribing and dispensing practices; and outreach and partnership with local organizations following enforcement operations, equipping and empowering communities to fight the opioid epidemic. The goals of the DEA 360 Strategy include stopping the deadly cycle of opioid CPD misuse and heroin use by eliminating the drug trafficking organizations and gangs fueling violence on the streets and addiction in communities.

Domestically, DEA focuses on the most significant distribution networks, including violent gangs with direct connections to drug cartels that funnel illegal drugs across our borders. DEA works closely with our state and local law enforcement partners through DEA Task Forces and shares real-time intelligence about particular drug threats that face our communities.

DEA created and implemented Tactical Diversion Squads (TDSs) to investigate suspected violations of the CSA and other federal and state statutes pertaining to the diversion of CPDs and listed chemicals. These unique groups combine the skill sets of Special Agents, Diversion Investigators, and a variety of state and local law enforcement agencies. They are dedicated solely towards investigating, disrupting, and dismantling those individuals or organizations involved in diversion schemes (e.g., "doctor shoppers," prescription forgery rings, and practitioners and pharmacists who knowingly divert CPDs).

In addition to DEA's law enforcement activities, DEA engages with industry to educate them regarding their responsibilities under the CSA. For example, DEA, along with state regulatory and law enforcement officials, and in conjunction with the National Association of Boards of Pharmacy, hosts Pharmacy Diversion Awareness Conferences (PDACs) throughout the country. These conferences are developed and designed to address the growing problem of diversion of CPDs at the retail level. The conferences address pharmacy robberies and thefts, forged prescriptions, doctor shoppers, and illegitimate prescriptions from rogue practitioners. The objective of these conferences is to educate pharmacists, pharmacy technicians, and pharmacy loss prevention personnel on methods to prevent and respond to potential diversion activity. Since DEA began hosting PDACs in 2011, we have trained over 10,300 pharmacy professionals in 32 states. There are an additional eight PDACs proposed in four states for the remainder of FY 2016.

DEA strongly supports the implementation and usage of prescription drug monitoring programs (PDMPs), which are valuable tools for prescribers, pharmacists, and law enforcement agencies to identify, detect, and prevent CPD misuse and diversion. PDMPs are typically state-run electronic database systems used by practitioners, pharmacists, medical and pharmacy boards, and law enforcement but access varies according to state law. These programs are established through state legislation and are tailored to the specific needs of a particular state. DEA strongly supports PDMPs and encourages the use of these programs by medical professionals in detecting and preventing doctor shopping and other diversion. Currently, the District of Columbia and 48

states have an operational PDMP (meaning collecting data from dispensers). Pennsylvania recently revised their PDMP, which should be operational this summer. Missouri still does not have an authorized PDMP.

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

It is important to note that DEA and our federal partners are working to address the interoperability problems in state PDMPs. SAMHSA has funded cooperative agreements to improve interoperability between PDMPs and Electronic Health Record (EHR) technology and provide real-time provider access. ONDCP and the Bureau of Justice Assistance (BJA) also offer assistance for interstate and state-tribal PDMP linkages. DEA also understands that the Centers for Disease Control (CDC) supports work in approximately 29 states to enhance and maximize PDMPs as public health and clinical tools in its Prevention for States program. Further, the Alliance of States with Prescription Drug Monitoring Programs, Brandeis University's PDMP Center of Excellence, and the Indian Health Service (IHS) are also partnering to improve interoperability between IHS, its pharmacies and PDMPs. The National Association of Boards of Pharmacy (NABP) hosts the NABP Prescription Monitoring Program (PMP) InterConnect, which facilitates the transfer of PDMP data across state lines to authorized users. The program allows users of participating PDMPs to securely exchange prescription data between certain states. Currently, PDMPs in 34 states are participating in the program.

Prescriber Education

7. **Given the high rates of both opioid prescriptions and opioid abuse, do you believe that it should be mandatory for prescribers to take classes on proper prescribing methods and recognizing and treating the signs and symptoms of substance abuse as a condition of obtaining and renewing their Drug Enforcement Administration registration to prescribe controlled substances? If not, why not? If you support a different compliance regime, what is it?**

Response:

As stated in the response to a previous question, on April 19, 2011, the Administration announced its response to the prescription drug overdose epidemic within the Plan, titled *Epidemic: Responding to America's Prescription Drug Abuse Crisis*, which expands upon the National Drug Control Strategy. The Plan focused action upon four major areas: education, tracking and monitoring, proper disposal, and enforcement. Under the education focus area, the Plan called upon ONDCP, FDA, SAMHSA, and DEA to work with Congress to amend the federal law to require practitioners who apply for a DEA registration to prescribe controlled substances be trained on responsible opioid prescribing practices as a precondition of registration. The training would include assessing and addressing signs of misuse and/or substance use disorders.

The appropriate use of CPDs – including opiates for indications such as pain management – is a necessary component of medical care to address the therapeutic needs of legitimate patients. However, when dispensed (including prescribed and administered) inappropriately or used improperly, CPDs pose serious risks and can cause serious negative consequences for individuals, families, and communities.

DEA continues to work with the ONDCP, the FDA, the SAMHSA, and Congress to require prescriber education regarding the appropriate uses, as well as the potential risks, of CPDs. This prescriber education is critical in national efforts to reduce opioid CPD misuse. DEA supports effective prescriber education, on a continuing basis, to help reduce inappropriate prescribing, misuse, and abuse of CPDs.

Questions for the Record posed by Senator Jeff Sessions

8. Wouldn't you agree that focusing on addiction treatment and recovery programs is insufficient to stop the heroin epidemic unless it is accompanied by strong enforcement of our drug laws?

Response:

DEA agrees that a robust strategy, including enforcement, treatment, and prevention, is necessary to stop the heroin epidemic. In addition to DEA's ongoing enforcement efforts, DEA is rolling out the 360 Strategy to address the prescription opioid, heroin, and violent crime crisis. The strategy leverages existing federal, state, and local partnerships to address the problem on three different fronts: law enforcement, diversion control, and community outreach and partnership. The strategy is founded upon our continued enforcement activities directed at the violent street gangs responsible for feeding the heroin and prescription drug abuse epidemic in our communities.

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

Following is a summary of the three key facets of the 360 Strategy.

Enforcement: A commitment to stopping violence associated with drug trafficking

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

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

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

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

DEA will engage with industry, practitioners, and government health organizations to facilitate an honest and frank discussion about the prescription drug misuse contributing to the current heroin epidemic. Additionally, DEA is studying ways, in collaboration with public health partners, to improve access to information that will help identify the nature of the drug abuse problem plaguing a particular area.

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

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

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

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

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

9. **With drug cartels trying to move so much heroin into the United States, would you agree with that keeping drug traffickers and dealers off the streets is an important part of keeping heroin from being readily available, abundant, and cheap?**

Response:

DEA agrees that the enforcement of drug laws is essential for decreasing the availability of drugs on our streets. DEA plays an important part in the U.S. government's drug control strategy that includes enforcement, treatment, and prevention. While there are complex issues affecting spikes in heroin use and overdoses, including prescription drug misuse, the same significant poly-drug trafficking organizations responsible for other illicit drug threats are also responsible for the vast majority of the heroin supply. Additionally, drug trafficking has a proven linkage to gangs and other violent criminal organizations. Ongoing actions to combat heroin proliferation include the following efforts.

Heroin Task Force

As directed by Congress, the Department of Justice joined with ONDCP to convene an interagency task force to confront the growing use and trafficking of heroin in America. DEA and more than 28 Federal agencies and their components participated in this initiative. The task force provided its Report to Congress on December 31, 2015. DEA will continue to work on the recommendations from the Heroin Task Force by developing a comprehensive strategy that will combine education, law enforcement, treatment and recovery, and a coordinated community response.

International Enforcement: Sensitive Investigative Units (SIU)

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

International Enforcement: Bilateral Investigations Units

Bilateral Investigations Units (BIUs) are one of DEA's most important tools for targeting, disrupting, and dismantling significant TCOs. The BIUs investigate, infiltrate, and acquire evidence to present in the grand jury to indict, arrest, and convict previously "untouchable" TCO leaders involved in drug trafficking.

Some recent examples of DEA's efforts to combat heroin proliferation include:

- On February 11, 2016, the DEA Wilmington, Delaware Resident Office's High Intensity Drug Trafficking Area (HIDTA) group executed two federal search warrants and a consent search that resulted in the seizure of approximately 48,800 bags of heroin, $40,000 in cash, two handguns, and six arrests. This was the largest seizure of prepackaged heroin in Delaware history.

- During Operation Deals on Wheels, on February 9, 2016, agents from the DEA Orlando, Florida District Office HIDTA Task Force Group 1 and officers from the Orange County (Florida) Sheriff's Office and the Orlando Police Department arrested Angel Contreras-Lozada and 11 other individuals, resulting in the dismantlement of his heroin trafficking organization. Weapons and money were seized during the investigation, including 223 grams of heroin. Among the 12 individuals arrested, one previously served 12 years in prison for a murder conviction and another one was recently released from prison for a conviction of possession with the intent to distribute heroin and possession of a firearm. During the past two years, the Contreras organization distributed at least four kilograms of heroin per month in the Orlando metropolitan area.

- On March 7, 2016, the DEA Guadalajara, Mexico Resident Office reported that elements from the Attorney General's Office of Jalisco and the Jalisco State Police, working in

coordination with the Guadalajara Resident Office, located and seized three fields containing a total of 162,000 opium plants and 15,600 marijuana plants in San Martin de Bolaños, Jalisco, Mexico. The first was an opium field measuring 1.5 acres in size with 150,000 opium plants. The second was an opium field co-mingled with marijuana plants which contained 12,000 opium plants and 4,800 marijuana plants. The third contained 10,800 marijuana plants. All of the plants were destroyed on site.