AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

METHAMPHETAMINE EPIDEMIC ELIMINATION ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON

H.R. 3889

SEPTEMBER 27, 2005

Serial No. 109–61

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE

23–641 PDF WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON THE JUDICIARY

F. JAMES SENSENBRENNER, JR., Wisconsin, *Chairman*

HENRY J. HYDE, Illinois
HOWARD COBLE, North Carolina
LAMAR SMITH, Texas
ELTON GALLEGLY, California
BOB GOODLATTE, Virginia
STEVE CHABOT, Ohio
DANIEL E. LUNGREN, California
WILLIAM L. JENKINS, Tennessee
CHRIS CANNON, Utah
SPENCER BACHUS, Alabama
BOB INGLIS, South Carolina
JOHN N. HOSTETTLER, Indiana
MARK GREEN, Wisconsin
RIC KELLER, Florida
DARRELL ISSA, California
JEFF FLAKE, Arizona
MIKE PENCE, Indiana
J. RANDY FORBES, Virginia
STEVE KING, Iowa
TOM FEENEY, Florida
TRENT FRANKS, Arizona
LOUIE GOHMERT, Texas

JOHN CONYERS, JR., Michigan
HOWARD L. BERMAN, California
RICK BOUCHER, Virginia
JERROLD NADLER, New York
ROBERT C. SCOTT, Virginia
MELVIN L. WATT, North Carolina
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
MARTIN T. MEEHAN, Massachusetts
WILLIAM D. DELAHUNT, Massachusetts
ROBERT WEXLER, Florida
ANTHONY D. WEINER, New York
ADAM B. SCHIFF, California
LINDA T. SÁNCHEZ, California
CHRIS VAN HOLLEN, Maryland
DEBBIE WASSERMAN SCHULTZ, Florida

PHILIP G. KIKO, *General Counsel-Chief of Staff*
PERRY H. APELBAUM, *Minority Chief Counsel*

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

HOWARD COBLE, North Carolina, *Chairman*

DANIEL E. LUNGREN, California
MARK GREEN, Wisconsin
TOM FEENEY, Florida
STEVE CHABOT, Ohio
RIC KELLER, Florida
JEFF FLAKE, Arizona
MIKE PENCE, Indiana
J. RANDY FORBES, Virginia
LOUIE GOHMERT, Texas

ROBERT C. SCOTT, Virginia
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
MARTIN T. MEEHAN, Massachusetts
WILLIAM D. DELAHUNT, Massachusetts
ANTHONY D. WEINER, New York

MICHAEL VOLKOV, *Acting Chief Counsel*
ELIZABETH SOKUL, *Special Counsel for Intelligence and Homeland Security*
JASON CERVENAK, *Full Committee Counsel*
BOBBY VASSAR, *Minority Counsel*

CONTENTS

SEPTEMBER 27, 2005

OPENING STATEMENT

Page

The Honorable Howard Coble, a Representative in Congress from the State of North Carolina, and Chairman, Subcommittee on Crime, Terrorism, and Homeland Security 1

The Honorable Robert C. Scott, a Representative in Congress from the State of Virginia, and Ranking Member, Subcommittee on Crime, Terrorism, and Homeland Security 2

WITNESSES

The Honorable Mark Souder, a Representative in Congress from the State of Indiana

Oral Testimony 5

Prepared Statement 7

The Honorable Mark Kennedy, a Representative in Congress from the State of Minnesota

Oral Testimony 16

Prepared Statement 17

Mr. Joseph T. Rannazzisi, Deputy Chief, Office of Enforcement Operations, U.S. Drug Enforcement Administration

Oral Testimony 18

Prepared Statement 20

Mr. Barry M. Lester, Ph.D., Professor of Psychiatry and Human Behavior and Pediatrics, Brown University Medical School

Oral Testimony 26

Prepared Statement 28

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable Robert C. Scott, a Representative in Congress from the State of Virginia, and Ranking Member, Subcommittee on Crime, Terrorism, and Homeland Security 47

Prepared Statement of Freda S. Baker, Deputy Director, Family and Children's Services, Alabama State Department of Human Resources 49

Prepared Statement of Laura J. Birkmeyer, Chair, National Alliance for Drug Endangered Children, and Executive Assistant to U.S. Attorney, Southern District of California, United States Department of Justice 55

Publication entitled "The Meth Epidemic in America, Two Surveys of U.S. Counties: The Criminal Effect of Meth on Communities, The Impact of Meth on Children, submitted by the National Associatino of Counties (NACo) 62

Letter from A. Bradford Card, Legislative Liaison, National Troopers Coalition to the Honorable Mark Souder and the Honorable Elijah Cummings 74

Letter from Donald Baldwin, Washington Director, Federal Criminal Investigators Association to the Honorable Howard Coble 75

Letter from Chuck Canterbury, National President, Grand Lodge Fraternal Order of Police (FOP) to the Honorable Mark Souder 76

Letter from William J. Johnson, Executive Director, National Association of Police Organizations, Inc. 78

Page

Prepared Statement of the Therapeutic Communities of America (TCA) 79
Prepared Statement of the Food Marketing Institute (FMI) 80
Prepared Statement of the American Council on Regulatory Compliance 82
Article entitled "The Mexican Connection," Steve Suo, June 5, 2005, *The Oregonian*, submitted by the Honorable Robert C. Scott 85
Article entitled "More potent supply of meth wipes out success against home labs," Steve Suo, September 25, 2005, *The Oregonian*, submitted by the Honorable Robert C. Scott 95
Letter from various medical and psychological researchers to the Subcommittee 100
Additional Prepared Statement of Dr. Barry M. Lester, Professor of Psychiatry & Human Behavior and Pediatrics, Brown University Medical School .. 107

METHAMPHETAMINE EPIDEMIC ELIMINATION ACT

TUESDAY, SEPTEMBER 27, 2005

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 4:02 p.m., in Room 2141, Rayburn House Office Building, the Honorable Howard Coble (Chair of the Subcommittee) presiding.

Mr. COBLE. Good afternoon, ladies and gentlemen. We welcome you all to this important hearing to examine the national epidemic of metham——

Meth—I did it without stumbling yesterday—with meth abuse; and specifically, H.R. 3889, the "Meth Epidemic Elimination Act," a bipartisan proposal which was introduced by Representative Souder, our friend from the heartland, and the Chairman of the full Judiciary Committee of the House.

In the last few years, the problem of meth abuse has grown dramatically from what was typically characterized as a local or a regional problem to a problem of national dimension. Some contend that meth is now the most significant drug abuse problem in the country, surpassing marijuana.

The impact of meth abuse is complicated by the dangerousness of the drug, the ease of production, the toxicity of the drug itself, the production byproducts, exposure of children to the drug when present in locations where meth is produced, the environmental cost of meth labs, and the significant strain of law enforcement resources resulting from enforcement and clean-up actions.

The National Association of Counties recently published a survey that revealed that 60 percent of responding counties stated meth was their largest drug problem. Sixty-seven percent reported increases in meth-related arrests.

Most of the meth found in the United States is produced by Mexico-based and California-based Mexican traffickers using superlabs. The rapid spread of meth, however, also can be attributed to the proliferation of small, toxic laboratories which have had a dramatic impact on communities across the nation.

No longer are these labs limited to what are termed "mom and pop labs," but now have become more sophisticated and organized production and distribution outlets; causing more and more law enforcement resources to be used to dismantle such operations and then to clean up the labs. As a result, local law enforcement agen-

cies are strained by the sheer number of these labs and the accompanying clean-up costs.

Meth labs also have been linked to significant instances of child abuse. Children face specific dangers from inhalation, absorption, or ingestion of toxic chemicals or contaminated food that may result in respiratory difficulties, chemical burns, or ultimately, death. Between 2000 and 2003, more than 10,000 children were affected by meth manufacturing. Approximately one in ten children tested positive for meth. And of those, children less than 6 years of age were twice as likely to test positive, as were children between the ages of seven and 14.

In San Diego, for example, more than 400 children have been taken into protective custody in the past 12 months. More than 95 percent of these children come from homes where there was meth use and trafficking.

The meth problem has significant consequences for the environment as well. The production of one pound of meth releases poisonous gas into the atmosphere, and creates 5 to 7 pounds of toxic waste. Many laboratory operators dump the toxic waste down household drains, in fields and yards, and onto rural roads. In 2004, the DEA administered over 10,000 State and local clandestine laboratory clean-ups at a cost of approximately $17.8 million.

Given the spread of meth abuse, and the near-crisis impact on local communities and law enforcement, there is no question that something must be done to resolve the problem, and done now.

I want to commend my colleagues; the Chairman, Chairman Sensenbrenner; Representative Souder; Representative Kennedy, from the northern tier; and others who have worked so diligently on this issue and recently introduced H.R. 3889, a bipartisan proposal which represents a good first step to addressing the problem. We are looking forward to hearing from our distinguished panel of witnesses.

And I am now pleased to recognize the distinguished gentleman from Virginia, the Ranking Member of this Subcommittee, the Honorable Bobby Scott.

Mr. SCOTT. Well, thank you, Mr. Chairman. And I'm pleased to join you in convening the hearing on Methamphetamine Epidemic Elimination Act. Unfortunately, I am not able to join you in supporting the bill in its present form.

In the last 15 to 20 years, meth abuse has grown to what some now refer to epidemic proportions in parts of this country. We've been making efforts in Congress for years to address the meth problem. The Subcommittee on Crime held six field hearings on production, trafficking, and use in 1999, in Arkansas, California, New Mexico, and Kansas. Testimony was received from numerous witnesses, including former addicts, family members of victims of meth-related violence, law enforcement professionals, prevention and addiction treatment professionals.

Despite what we heard about the need for treatment and family support to get people out of meth's grip and back on track, the basic approach of Congress has been to increase the number of severe mandatory minimum sentences. Yet, the fact is that this approach clearly has not worked to stem the tide of meth. In fact, there's no evidence to suggest that it ever will.

Evidence shows that treatment works to stem addiction and abuse. Recently, in an open letter to the news media and policymakers, 92 researchers and treatment professionals stated that, and I quote:

"Claims that meth users are virtually untreatable, with small recovery rates, lack foundation in medical research. Analysis of dropout, retention and treatment, and reincarceration rates, and other measures of outcome in recent studies indicate that meth users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests that the need to improve and expand treatment offered—Research also suggests the need to improve and expand treatment offered to meth users."

Drug courts have proven especially successful in the case of meth treatment as an alternative to the "get tough" approach. An Orange County, California, Superior Court drug court program is an example of a program that has effectively addressed the meth problem. The court requires a minimum of an 18-month treatment program in which a graduate must be drug-free for at least 6 months, have stable living arrangements, and be employed or enrolled in school.

This has shown to have a significant retention rate, with a much lower recidivism rate than you would expect for drug users. Nonetheless, time and time again, Congress has responded to this serious problem primarily with more and harsher mandatory minimums.

In the Anti-Drug Abuse Act of 1988, Congress established a 5-year mandatory minimum for 10 grams of pure meth or 100 grams of meth mixture, and a 10-year minimum for 100 grams. In 1999, Congress heightened the sentencing for "ice." Then again, in 1996, Congress responded to the still growing problem with even tougher mandatory minimums, by cutting in half the quantities of the substance that would trigger the 5- and 10-year mandatory minimums.

In the meanwhile, the epidemic has grown exponentially, despite these ever increasing punitive measures passed by Congress. And States, unfortunately, have taken a similar approach: enacting harsher and harsher penalties, putting more and more emphasis on law enforcement. Yet they have had no more success than Congress with this approach.

And a recent series of articles in the Oregonian newspaper reflected the frustrating results of this approach in Oklahoma. And Mr. Chairman, I ask unanimous consent to place this article in the record.

Mr. COBLE. Without objection.

Mr. SCOTT. The article pointed out that while Oklahoma had great success in slashing the number of home meth labs through vigorous law enforcement, it failed to curb meth use. They found that in place of local labs, a massive influx of meth made by Mexican superlabs—where tons of the predicate, the precursor chemicals, can be obtained—had come into their locality. And this they found was cheaper and better quality than the locally made stuff.

Despite the clear evidence that increasing penalties do not stem the spread or impact of meth, and despite the evidence that treatment does significantly decrease the problem, the response in this

bill, yet again, is to increase mandatory minimum sentences even more.

This bill would further lower the threshold amount of meth that triggers harsh mandatory minimums. The main problem with this approach is that it will actually make meth more available. This is because lowering the quantity threshold of triggering mandatory minimums will cause Federal prosecutors to concentrate even more on low-level offenders that are now being left to the States to prosecute. This will simply mean that we will be sentencing the same low-level offenders with longer sentences, including those who are tied up in conspiracy and attempt laws which punish bit players the same as kingpins.

This is what we have seen with the so-called crack epidemic, where we are seeing that over two-thirds of those sentenced for crack are low-level offenders—generally, addicts dealing to supply their habit. And now, here we go in what Yogi Berra would say is "deja vu all over again."

So Mr. Chairman, I look forward to the testimony of our witnesses. And I hope that they will enlighten us on proven ways to stem this problem; rather that simply doing what we always do: put low-level addicts in prison longer, while the problem continues on. I yield back.

Mr. COBLE. I thank the gentleman from Virginia. And we have been joined by the distinguished gentleman from Massachusetts, Mr. Bill Delahunt. Bill, good to have you with us as well.

It is the practice of the Subcommittee, gentlemen, to swear in the witnesses, if you all will stand and raise your hands.

[Witnesses sworn.]

Mr. COBLE. Let the record show that each of the witnesses answered in the affirmative. You may be seated.

Today we have four distinguished witnesses before us, and we appreciate your attendance. And we appreciate, those in the audience, your attendance as well.

Our first witness is the Honorable Mark Souder. Representative Souder serves the Third Congressional District in the State of Indiana. He was first elected to the Congress in 1994. He currently serves as Chairman of the Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources.

Prior to serving in Congress, Representative Souder worked for former U.S. Senator Dan Coates for 10 years. Last week, Representative Souder introduced H.R.3889, after conducting extensive hearings on the meth abuse issue.

Our second witness is the Honorable Mark Kennedy. Representative Kennedy serves the Sixth Congressional District of the State of Minnesota, and was first elected to the Congress in 2000. He is currently a Member of the Transportation and Infrastructure Committee and the Financial Services Committee.

Prior to serving in Congress, Representative Kennedy had a successful 20-year business career. And he also dedicated himself to meth abuse issues, and played a critical role in the formulation of the bill before us, H.R.3889.

Our third witness is Joseph Rannazzisi, the Deputy Chief of the Office of Enforcement Operations at the Drug Enforcement Administration. Mr. Rannazzisi is also assigned the position of Acting-

Deputy Assistant Administrator of the Office of Diversion Control. In this capacity, he oversees the office's effort to protect—detect and investigate the diversion of pharmaceutical controlled substances.

Previously, he served as assistant special agent in charge at the DEA Detroit field office, and as section chief of the dangerous drugs and chemicals section, where he coordinated clandestine laboratory enforcement operations worldwide. He received a B.S. in pharmacy from Butler University, and a J.D. from the Michigan State University.

Our final witness today is Dr. Barry Lester, professor of psychiatry and human behavior at Brown University School of Medicine. Dr. Lester is also director of the Brown Center for the Study of Children at Risk, and the Infant Development Center. He is currently a member of the National Institutes of Health's National Advisory Council on Drug Abuse, and the Family Treatment Drug Court Steering Committee.

Previously, Dr. Lester worked as an assistant professor of pediatrics at the Harvard School of Medicine. He earned his undergraduate degree at Boston University, and his Ph.D. from the Michigan State University.

And as I said earlier, gentlemen, good to have you all with us. And I want to apologize in advance. I must attend a Coast Guard homeland security briefing at five o'clock at the Transportation Committee, so I will be departing then. But do not mistake my departure for lack of interest in this very important subject. And I will follow up what I missed in the interim subsequently.

Gentlemen, we adhere to the 5-minute rule here. And your first 4 minutes, you will see a green light in the panel before you. An amber light will then appear, advising you that you have 1 minute to go. At the end of that 5 minutes, then Mr. Scott and I will call the U.S. marshal to haul you into—I'm kidding you. [Laughter.]

But if you could, adhere to that red light. When the red light appears, that is your indication that the 5 minutes have elapsed. We have read your written testimony, and will reexamine it.

Again, we're delighted to have you all with us to address problems surrounding this very, very serious encounter that we face every day. And Mr. Souder, we will start with you.

TESTIMONY OF THE HONORABLE MARK SOUDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. SOUDER. Thank you, Mr. Chairman. And first, greetings from Indiana, where we buy your wonderful North Carolina furniture—that is, whatever isn't made in China—and also, supply you with basketball players, so you can look respectable in North Carolina. [Laughter.]

Mr. COBLE. Well, now, if the gentleman will suspend—and I won't penalize your time—the furniture, I hope, came from my district, the furniture capital of the world—or at least, it was last month.

Mr. SOUDER. I thank the Chairman, and I thank you and Ranking Member Scott and Members of the Subcommittee for inviting me to testify on behalf of the Methamphetamine Epidemic Elimination Act. I believe this is a vital first step, a bipartisan step, and

I hope the Subcommittee and the full Committee will support its passage.

I could fill my whole time thanking different Members, but first I'd like to thank Chairman Sensenbrenner of the full Committee, and you, Chairman Coble, for co-sponsoring this bill and the assistance of your staff in putting this together. I'd also like to thank Majority Whip Roy Blunt for his co-sponsorship, and Representative Mark Kennedy and Representative Darlene Hooley for providing much of the content of this bill and for their consistently strong leadership on the House floor on meth issues; as well as the four co-chairs of the Congressional Meth Caucus, Representative Rick Larsen, Representative Ken Calvert, Representative Leonard Boswell, and Representative Chris Cannon, for their and their staffs' assistance and support. And to every other Member who has co-sponsored this bill, I express my deep appreciation.

I don't have to tell you, and I'm not going to get into the details of the meth threat, but as Chairman of the Government Reform Subcommittee on Criminal Justice, we've held ten hearings since 2001, not only in Washington, D.C., but rural Arkansas, Ohio, Indiana, suburban and urban Minnesota, California, Hawaii, and urban Detroit. There are regional and local variations of the problem, but one thing remains constant: it's almost unique in its combination of cheapness, ease of manufacture, and devastating impact on the user and the community.

There are three aspects we need to make sure that we look at when we're looking at these types of things. First, meth presents a unique challenge to Federal, State, and local law enforcement. It's toxic. It ties up local law enforcement, and causes lots of money to be spent in clean-up.

Secondly, the damage this drug causes is not confined to the addict. It's terrible effects on everyone around the user, particularly children. California did the first child abuse law related to this; and child welfare agencies said 40 percent of child welfare in Saint Paul, Minnesota. We heard that it, from a standing start, in 12 months, went from zero to 80 percent of the kids in child protection were from meth parents.

And I'd also like, with your permission, Mr. Chairman, to introduce the county survey that showed that it was the number one problem—their association survey—into the record, along with statements from two experts on the impact of meth on children that were provided to my Subcommittee in July.

Mr. COBLE. Without objection.

Mr. SOUDER. The third major point is the meth threat is not confined to small local labs, but extends well beyond our borders to the superlabs controlled by large, sophisticated Mexican drug trafficking organizations and the international trade in pseudoephedrine and other precursor chemicals fueling those superlabs.

As Mr. Scott mentioned, you can't just push one, or you'll go over to the other. You have to have a combination strategy. Any legislation that tries to deal with the meth threat must address all these critical aspects.

After meeting with Chairman Wolf, who after reading a couple of amendments on the House floor said, "Let's see if we can do

something in combination, tie it to the appropriations bills, because we know they have to pass the Senate, and we need to take some meth action this year." After meeting with him and a bipartisan group of nearly 20 other Members in my office who are deeply concerned about this, we worked with my Subcommittee, with the meth caucus, as well as your Committee and other authorizing Committees to come up with this package.

It includes the following four basic categories: First, close a number of loopholes in Federal regulation of meth precursor chemicals, such as pseudoephedrine, including a per-transaction sales limit; import and manufacturing quotas, to ensure no oversupply leads to diversion. Mexico is pouring in huge amounts over what they need; regulation of the wholesale spot market.

A second is, require reporting of major meth precursor exporters and importers, and would hold them accountable for their efforts to prevent diversion to meth production.

Three, toughen Federal penalties against meth traffickers and smugglers—has nothing to do with possession; only possession with intent to traffic.

Four, apply environmental regulations to those who harm the environment and endanger human health through meth lab operation.

Each of these are vital. But we need to remember, we did not address two things. We do not address the issue of pseudoephedrine or similar chemical products that should be added to Schedule V. I have personal reservations with this, but this bill is silent on this, and it could be in combination with that or not.

Secondly, we did not include any significant new grant programs for State and local agencies to deal with meth. I believe we need to do more in treatment. I believe we need to do more in multiple areas. This is the Judiciary Committee. You're not in the grant business. And we need to look at how to do more; as we do drug treatment, how to make some of that targeted toward meth. That I agree with, but this isn't the bill to do that.

I yield back the balance.

[The prepared statement of Mr. Souder follows:]

PREPARED STATEMENT OF THE HONORABLE MARK E. SOUDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Chairman Coble, Ranking Member Scott, and Members of the Subcommittee, thank you for inviting me to testify in support of H.R. 3889, the "Methamphetamine Epidemic Elimination Act." I believe this bipartisan bill is a vital first step in our renewed fight against the scourge of methamphetamine trafficking and abuse, and I hope the Subcommittee and full Committee will support its passage.

I would probably fill my entire five minutes if I tried to thank each of the Members and staff who helped with this legislation, so I will have to mention only a few. First, I'd very much like to thank Chairman Sensenbrenner of the full Committee, and you, Chairman Coble, for cosponsoring the bill and for the assistance your staff provided in putting it together. Next, I'd like to thank Majority Whip Roy Blunt for his cosponsorship; Rep. Mark Kennedy and Rep. Darlene Hooley for providing much of the content of this bill, and for their consistently strong leadership on the House floor on meth issues; and the four co-chairs of the Congressional Meth Caucus, Rep. Rick Larsen, Rep. Ken Calvert, Rep. Leonard Boswell, and Rep. Chris Cannon, for their and their staff's assistance and support. And to every other Member who has cosponsored the bill, I express my deep appreciation.

I don't have to tell any of you how serious a threat meth is for our communities; pick up almost any newspaper or magazine these days and you can read about it firsthand. As chairman of the Government Reform Committee's Subcommittee on

Criminal Justice, Drug Policy and Human Resources, I have held ten hearings on the meth epidemic since 2001, not only in Washington, D.C., but in places as diverse as rural Arkansas, Ohio, and Indiana, suburban Minnesota, island Hawaii, and urban Detroit. There are regional and local variations on the problem, of course, but one thing remains constant everywhere: this is a drug almost unique in its combination of cheapness, ease of manufacture, and devastating impact on the user and his or her community.

There are three aspects of the meth epidemic that I believe need to be emphasized as Congress considers this and related legislation. First, meth presents unique challenges to federal, state, and local law enforcement. The small, clandestine meth labs that have spread like wildfire across our nation produce toxic chemical byproducts that endanger officers' lives, tie up law enforcement resources for hours or even days, and cost tremendous amounts of money to clean up. That, combined with the rise in criminal behavior, child and citizen endangerment, and other effects, have made meth the number one drug problem for the nation's local law enforcement agencies, according to a study released over the summer by the National Association of Counties, which I'd like to enter into the record.[1]

Second, the damage this drug causes is not confined to the addict alone; it has terrible effects on everyone around the user, particularly children. Another survey by the National Association of Counties found that 40 percent of child welfare agencies reported an increase in "out of home placements because of meth in the past year."[2] This abuse unfortunately includes physical and mental trauma, and even sexual abuse. 69 percent of county social service agencies have indicated that they have had to provide additional, specialized training for their welfare system workers and have had to develop new and special protocols for workers to address the special needs of the children affected by methamphetamine.[3] With your permission, Mr. Chairman, I'd like to introduce the Association's survey into the record, together with the statements of two experts on the impact of meth on children, which were provided to my subcommittee in July. They illustrate how community health and human services, as well as child welfare services such as foster-care, are being overwhelmed as a result of meth.[4]

Finally, the meth threat is not confined to the small, local labs, but extends well beyond our borders to the "super labs" controlled by large, sophisticated Mexican drug trafficking organizations, and the international trade in pseudoephedrine and other precursor chemicals fueling those super labs. Three-quarters or more of our nation's meth supply is controlled by those large organizations, and over half of our meth comes directly from Mexico. With your permission, I'd also like to introduce an excellent group of articles from the Oregonian newspaper that detail the international aspects of the meth trade.[5]

Any legislation that tries to deal with the meth threat must address these critical aspects, and we have tried to do that in this legislation. We began the process of drafting the bill several months ago, when Chairman Frank Wolf of the Appropriations Committee's Science-State-Justice-Commerce Subcommittee approached me on the House floor and offered his assistance in passing anti-meth legislation. After meeting with him and nearly twenty other Members who are deeply concerned about the meth epidemic, I asked my subcommittee staff, after consultation with staff for the Meth Caucus Members, as well as the relevant authorizing committees, to assemble a package of proposals that would enjoy strong, bipartisan support. That package ultimately became this bill.

I've attached a detailed section-by-section analysis to my written statement for your review, so I will briefly mention the highlights of the bill. Among other things, the Act would:

- close a number of loopholes in federal regulation of meth precursor chemicals such as pseudoephedrine, including a per-transaction sales limit; import and manufacturing quotas to ensure no oversupply leads to diversion; and regulation of the wholesale "spot market";

---

[1] National Association of Counties (NAoC) survey, "The Criminal Effect of Meth on Communities," July 5, 2005.

[2] *Ibid.*

[3] *Ibid.*

[4] Statements of Laura J. Birkmeyer, Chair, National Alliance for Drug Endangered Children, and Director, National Methamphetamine Chemicals Initiative; and Freida S. Baker, MSW, Deputy Director, Family and Children's Services, Alabama State Department of Human Resources; presented to the Subcommittee on Criminal Justice, Drug Policy and Human Resources, July 26, 2005.

[5] "The Mexican Connection," and "Mexico's Math Problem Adds Up to a U.S. Meth Problem," Steve Suo, the *Oregonian,* June 5, 2005.

- require reporting of major meth precursor exporters and importers, and would hold them accountable for their efforts to prevent diversion to meth production;
- toughen federal penalties against meth traffickers and smugglers; and
- apply environmental regulations to those who harm the environment and endanger human health through meth lab operation.

Each of these steps is vital to our success in the fight against meth, and I hope that the Subcommittee and the full Committee will support them.

Finally, I'd like to say a word or two about two key issues not addressed in the bill. First, we did not address the issue of whether pseudoephedrine and similar chemical products should be added to Schedule V of the federal Controlled Substances Act. The Schedule V issue is already dealt with by the Combat Meth Act (H.R. 314 / S. 103), and thus there was no need for us to include it in our legislation. I myself have some concerns about the Schedule V approach, which I believe may have unintended consequences for consumers, retailers, and the health care system. However, I look forward to working with Mr. Blunt and other supporters of that legislation to see if we can forge a workable solution.

Second, we did not include significant new grant programs for state and local agencies to deal with meth, nor did we attempt to amend or revise existing grant programs. I do believe that Congress must address the question of how best to help our beleaguered state and local law enforcement, child welfare, and treatment and prevention agencies deal with this incredibly destructive and expensive drug threat. That issue is very complex, however, and will require extensive review by the authorizing committees before it can be resolved.

Mr. Chairman, every one of us, regardless of where we come from, has a stake in the outcome of this fight. We have to stop the meth epidemic from spreading, and we need to start rolling it back. I believe that H.R. 3889 will be an important step in that process. Thank you again for the opportunity to testify here today, and I would be happy to answer any questions that you and the other Members may have.

ATTACHMENT

H.R. 3889

METHAMPHETAMINE EPIDEMIC ELIMINATION ACT

Section-by-Section Analysis

Title I – Domestic Regulation of Precursor Chemicals

Sec. 101. Regulated Transactions in Methamphetamine Precursor Chemical Products

This section repeals the federal "blister pack" exemption, reduces the federal per-transaction sales limit for pseudoephedrine, ephedrine, and phenylpropanolamine products from 9 grams to 3.6 grams (the amount recently proposed by the Administration), and clarifies the law to include derivatives of each of these chemicals.

When Congress first increased the regulation of meth precursor chemicals in the 1990's, it created a special exemption for pseudoephedrine products contained in "blister packs" (the small plastic-and-foil packages that force a consumer to pop out cold pills one or two at a time). The theory was that these packages, being somewhat more difficult to open and empty *en masse* than bottles, would deter meth cooks from using them. It has not proven to be enough of a deterrent, however, and meth cooks have taken advantage of their ability under federal law to buy as many packages as they want.

This section would preserve the incentive to keep cold pills in blister packs, while subjecting them to the new sales limit. If pseudoephedrine, ephedrine, or phenylpropanolamine products are sold in pill form, they must be in blister packs to be sold over the counter; otherwise, they must be in liquid form. All forms of these products would now be subject to the 3.6 grams per transaction limit, without exception.

Subsections (b) and (c) make conforming amendments to the current law, to accommodate the new sales restrictions. Subsection (d) makes another technical correction to make it clear that these sales limitations apply to drug combinations containing derivatives of pseudoephedrine, ephedrine, or phenylpropanlamine.

Sec. 102. Authority To Establish Production Quotas

This section extends the Attorney General's existing authority to set production quotas for certain controlled substances (see 21 USC 826) to pseudoephedrine, ephedrine, and phenylpropanolamine. Currently, domestic production of these chemicals is not very high, as most of our supply is imported. If Congress adopts the import quotas enacted by Section 104 of the bill (see below), however, the Attorney General would need to have corresponding authority within the U.S. if domestic production were to increase. Current law (as amended) would allow manufacturers to apply for increases in their production quotas (see 21 USC 826(e)).

Sec. 103. Penalties; Authority for Manufacturing; Quota

This section would expand the existing penalty for illegal production beyond established quotas (see 21 USC 842(b)) to take into account the Attorney General's new authority to set quotas for meth precursors.

Sec. 104. Restrictions on Importation; Authority To Permit Imports for Medical, Scientific, or Other Legitimate Purposes

This section would extend the Attorney General's existing authority to set import quotas for controlled substances (see 21 USC 952) to pseudoephedrine, ephedrine, and phenylpropanolamine. This section contains provision allowing registered importers to apply for temporary or permanent increases in a quota to meet legitimate needs, which would have to be acted on within 60 days.

Sec. 105. Notice of Importation or Exportation; Approval of Sale or Transfer by Importer or Exporter

This section would fix a hole in the current regulatory system for imports and exports of precursor chemicals for methamphetamine and other synthetic drugs. Under current law, an importer or exporter who wishes to import pseudoephedrine or other precursor chemicals must either (1) notify the Department of Justice 15 days in advance of the import or export, or (2) be a regular importer or exporter (i.e., a company that the Department has previously allowed to import or export), and planning to sell the chemicals to a regular customer (again, one that the Department has previously permitted to take delivery). (See 21 USC 971(a) and (b).)

A problem can arise, however, when the sale that the importer or exporter originally planned on falls through. When this happens, the importer or exporter must quickly find a new buyer for the chemicals on what is called the "spot market" – a wholesale market. Sellers are often under pressure to find a buyer in a short amount of time, meaning that they may be tempted to entertain bids from companies without a strong record of preventing diversion. More importantly, the Department of Justice has no opportunity to review such transactions in advance and suspend them if there is a danger of diversion to illegal drug production.

This section would extend the current reporting requirements – as well as the current exemption for regular importers, exporters, and customers – to post-import or export transactions. If an importer or exporter was required to file an initial advance notice with the Department of Justice 15 days before the shipment of chemicals, and the originally planned sale fell through, the importer or exporter would then have to file a second advance notice with the Department identifying the new proposed purchaser. The Department would then have 15 days to review the new transaction and decide whether it presents enough of a risk of diversion to warrant suspension. As is the case under existing law, a suspension can be appealed through an administrative process. (See 21 USC 971(c)(2).)

If, however, an importer or exporter was exempted from filing an initial advance notice because it qualifies as a "regular" importer or exporter under existing law, that importer or exporter would not have to file the second advance notice, as long as the new proposed purchaser also qualifies as a "regular" customer under existing law. (Note that under current law, the Department does receive a record of these transactions after the fact, see 21 USC 971(b)(1).)

Sec. 106. Enforcement of Restrictions on Importation and of Requirement of Notice of Transfer

This section makes a conforming amendment to current law, to extend existing penalties for illegal imports or exports to the new regulatory requirements added by sections 104 and 105 of the bill.

Title II – International Regulation of Precursor Chemicals

Sec. 201. Information On Foreign Chain Of Distribution; Import Restrictions Regarding Failure Of Distributors To Cooperate.

This provision (originally introduced by Rep. Darlene Hooley) would further amend the reporting requirements for importers of meth precursor chemicals, by requiring them to file with federal regulators complete information about the chain of distribution of imported chemicals (from the manufacturer to the shores of the U.S.). This will help U.S. law enforcement agencies to better track where meth precursors come from, and how they get to the U.S. At present, very little information exists about the international "chain of distribution" for these chemicals, hindering effective controls.

Sec. 202. Requirements Relating To The Largest Exporting And Importing Countries Of Certain Precursor Chemicals.

This provision (originally introduced by Rep. Mark Kennedy) was adopted by the House as part of the State Department reauthorization legislation for FY 2006-07 (H.R. 2601). It would mandate a separate section of the current State Department report on major drug producing and transit countries (see 22 USC 2291h), identifying the 5 largest exporters of major methamphetamine precursor chemicals, and the 5 largest importers that also have the highest rate of meth production or diversion of these chemicals to the production of meth. If any of those countries were not fully cooperating with U.S. law enforcement in implementing their responsibilities under international drug control treaties, there would be consequences for their eligibility for U.S. aid, similar to those faced by the major drug trafficking nations under current law.

We have added a provision clarifying the original intent of this amendment, to apply the "fully cooperates" standard (and not the lesser standard under another, separate provision of law). The provision also includes authorization of $1 million for implementation. The House recently passed an amendment to the State Department's

appropriations bill for FY '06, adding $5 million for the Department to implement anti-meth measures; this $1 million could come out of that amount.

Sec. 203. Prevention Of Smuggling Of Methamphetamine Into The United States From Mexico.

This amendment would require the State Department's Bureau for International Narcotics and Law Enforcement Affairs (INL) to provide assistance to Mexico to prevent the production of methamphetamine in that country, and to encourage Mexico to stop the illegal diversion of meth precursor chemicals. The amendment would authorize the use of $4 million of the $5 million recently approved by the House for these purposes. (The remaining funds would be available to help the State Department implement Sec. 202, described above.)

Title III – Enhanced Criminal Penalties for Methamphetamine Production and Tracking

Sec. 301. Enhanced Penalties for Methamphetamine Production, Possession, or Trafficking

This section (originally proposed by Rep. Mark Kennedy, and reflecting changes suggested by the Judiciary Committee staff) amends the Controlled Substances Act and the Controlled Substances Import and Export Act, to increase the penalties for producing, trafficking, or smuggling methamphetamine.

Subsection (a) would impose higher penalties on the production or trafficking of meth or its precursor chemicals, by amending 21 USC 841 both to lower the threshold amounts for certain penalties already set by law, and actually to increase the mandatory minimum punishment for certain crimes.

Under current law, the penalties for meth production or trafficking are based on the amount involved, the number of prior convictions for drug trafficking, and whether death or serious injury resulted from the drugs involved. (See 21 USC 841(b).) The highest penalty (mandatory minimum of 10 years for a first offense, 20 years for a second offense, and life imprisonment if a third offense) is currently imposed if the amount of meth involved is 50 grams or more, or 500 grams or more of a substance containing a detectable amount of meth. This bill would lower those threshold amounts to 5 grams and 50 grams, respectively.

Similarly, the next highest penalty (mandatory minimum of 5 years for a first offense, 10 years if a second offense) is currently imposed for 5 grams or more of meth, or 50 grams or more of a detectable amount of meth. This bill would lower those thresholds to 3 and 30 grams, respectively.

Subsection (b) would make identical changes to the law governing illegal imports and exports of meth.

Sec. 302. Smuggling Methamphetamine or Methamphetamine Precursor Chemicals into the United States While Using Facilitated Entry Programs.

Even as more meth is being smuggled across the border, increased legitimate international traffic has forced the bureau of Customs and Border Protection (CBP) to rely on facilitated entry programs – so-called "fastpass" systems like SENTRI (for passenger traffic on the Southwest border), FAST (for commercial truck traffic), and NEXUS (for passenger traffic on the Northern border). These systems allow pre-screened individuals to use dedicated lanes at border crossings, subject only to occasional searches to test compliance with customs and immigration laws.

These programs can be a powerful tool for CBP to manage heavy traffic at major border crossings, but they can also create potential risks. If a drug trafficking organization were to hire someone cleared for a "fastpass" system, it could smuggle large amounts of drugs through only minimal security. The problem is compounded by the fact that computerized criminal background checks cannot be performed in Mexico, meaning that our ability to screen Mexican citizens who apply for a fastpass system is minimal at best.

This section (originally proposed by Rep. Mark Kennedy) would create an added deterrent for anyone to misuse a facilitated entry program to smuggle methamphetamine or its precursor chemicals. An additional penalty of up to 15 year's imprisonment would be added to the punishment for the base offense. If convicted, an individual would also be permanently barred from using a fastpass system again.

Sec. 303. Manufacturing Controlled Substances on Federal Property.

This provision (originally proposed by Rep. Mark Kennedy) would clarify that current penalties for cultivating illegal drugs on federal property also apply to manufacturing synthetic drugs (such as meth). Meth cooks have frequently moved their operations to parks, national forests, and other public lands, causing serious environmental damage. This criminal penalty can help deter such destructive conduct.

Sec. 304. Increased Punishment for Methamphetamine Kingpins.

This provision (recommended by the staff of the Judiciary Committee) would allow for easier application to major meth traffickers of the enhanced penalties of the "continuing criminal enterprise" section of the Controlled Substances Act (21 U.S.C. 848). That section (commonly referred to as the "kingpin" statute) imposes life imprisonment on a leader of a drug trafficking organization convicted of trafficking in very large quantities of a drug, and receiving very large profits from that activity. This new provision would reduce the threshold amount of meth (from 300 to 100 times the threshold for base violations) and profits from meth (from $10 million to $1 million),

while still applying the life imprisonment penalty only to true "kingpins" – the ringleaders of meth trafficking organizations.

Title IV—Enhanced Environmental Regulation of Methamphetamine By-Products

Sec. 401. Designation of By-Products of Methamphetamine Laboratories as Hazardous Materials and Waste Under Hazardous Materials Transportation Act and Solid Waste Disposal Act.

This provision (originally contained in the CLEAN-UP Meth Act introduced by former Rep. Doug Ose, and currently sponsored by Rep. Mark Kennedy) would give additional authority to the Transportation Department and the Environmental Protection Agency (EPA) to enforce environmental regulations against meth cooks who cause pollution with meth by-products. The provision has been amended to require consultation by the Secretary of Transportation and the Administrator of the EPA with the Attorney General.

Sec. 402. Cleanup Costs

This provision (originally proposed by Rep. John Peterson) would clarify existing law imposing the obligation of restitution for environmental cleanup costs on persons involved in meth production and trafficking. The recent decision of the Eighth Circuit Court of Appeals in *United States v. Lachowski* (405 F.3d 696) (8th Cir. 2005) has undermined the ability of the federal government to seek cleanup costs from meth traffickers who are convicted only of meth possession – even when the meth lab in question was on the defendant's own property. This provision would ensure that any person convicted of a meth-related offense can be held liable for clean-up costs for meth production that took place on the defendant's own property, or in his or her place of business or residence.

Mr. COBLE. I thank the gentleman from Indiana.

The gentleman from Minnesota, Mr. Kennedy.

THE HONORABLE MARK KENNEDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. KENNEDY. Chairman Coble, Ranking Member Scott——

Mr. COBLE. Mr. Kennedy, if you would suspend just a minute, we've been joined by the gentleman from Florida, Mr. Feeney, and the distinguished gentleman from Ohio, Mr. Chabot.

Mr. KENNEDY. And the Members of the Committee, I'd like to thank you first of all for holding this hearing on a very important issue, the Methamphetamine Epidemic Elimination Act. I'd also like to thank Chairman Sensenbrenner and Chairman Souder for his interest in this.

This bipartisan legislation, sponsored by Representatives Souder, Sensenbrenner, Blunt, and myself and others, is one of the most significant pieces of legislation that has been offered to respond comprehensively to the scourge of methamphetamine.

Mr. Chairman, our communities face many challenges, from keeping our kids safe in our neighborhoods to the war on terrorism; but few have such immediate consequences as we face with meth. For years, meth's threat has been underestimated. It is now clear to almost everyone that meth threatens lives, safety, and health, at great cost to all of us.

A recent study by the University of Illinois conveyed shocking stories of 10-year-old children becoming surrogate parents to their younger siblings, as their parents cycled through day-long highs, often accompanied by psychotic symptoms, followed by crashes and days of sleep. According to the Illinois study, the children of alcoholics were said to have a thunderstorm of problems, but the children of meth addicts suffer a tornado of trauma. They are at an extraordinary level of risk of mental health and substance abuse disorders.

Parents making the drug in their homes have exposed their children to toxic fumes and the danger of explosions or fires. Some ask their children to steal items needed for making of meth, or to stand guard, armed with a gun, looking out for police and other authorities.

Mr. Chairman, I have often spoken about the tragic story of a young girl named Megan, from a beautiful town in my home State of Minnesota. Megan got started on meth when she was in seventh grade, at the age of 13. One of her friends offered her the drug and, in her words, she liked meth so much that she knew she would do it again and again.

Well, when she became—when she couldn't afford her addiction, she, like so many other female addicts, was exploited into becoming a prostitute to pay for the meth she craved every second of the day. After hitting bottom at age 18, Megan has managed to pull her life together now, after the 5 years that meth stole from her. But she has too much company in her treatment and addiction programs.

About one in five of those treated for methamphetamine use in the State of Minnesota are 17 years old or younger. As Members of Congress, in the face of so much suffering, we have an obligation

to act. This bill brings together a number of proposals made by many of my colleagues to fight this devastating scourge.

I am pleased that H.R.3889 includes provisions I drafted to increase criminal penalties on meth pushers, to target the international superlabs that are the source of so much of this poison, and language from my Clean Up Meth Act to assist communities in dealing with the environmental destruction from meth production.

Mr. Chairman, I thank you for holding this hearing here today. I'd like to thank again the witnesses who agreed to come to speak about the ravages of methamphetamine. I urge the swift passage of this important legislation. Doing so will send a strong signal that Congress is serious about fighting the scourge of meth.

We must send a signal to the pushers of this poison that they are not welcome in our communities. Most importantly, we must send a signal to the law enforcement officers who wake up every morning to protect our families that we stand with them in the fight against drugs, and will work to give them every tool they need to be successful.

Mr. Chairman, I ask for my full statement to be made part of the record, and yield back the remainder of my time.

[The prepared statement of Mr. Kennedy follows:]

PREPARED STATEMENT OF THE HONORABLE MARK KENNEDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESTORA

Chairman Coble, Chairman Sensenbrenner, Ranking Member Scott, Members of the Subcommittee, I'd like to begin by thanking you for holding this hearing on H.R. 3889, the Methamphetamine Epidemic Elimination Act.

This bipartisan legislation, sponsored by Reps. Souder, Sensenbrenner, Blunt and myself is one of the most significant pieces of legislation that has been offered to respond comprehensively to the scourge of methamphetamine.

Mr. Chairman, there are 128 members in the Congressional Caucus to Fight Methamphetamine; these members represent districts all across this country.

They know that methamphetamine is no longer a western problem or a rural problem; it is a problem that has infiltrated every corner of virtually every Member's district in this country.

Mr. Chairman, our communities face many challenges, from keeping our kids safe in our neighborhoods to the war on terrorism.

But few have such immediate consequences as we face from meth. For years, meth's threat was underestimated. It is now clear to almost everyone: meth threatens lives, safety and health, at great cost to all of us.

A recent study by the University of Illinois conveyed shocking stories of 10-year-old children becoming surrogate parents to their younger siblings as their parents cycled through days-long highs, often accompanied by psychotic symptoms, followed by crashes and days of sleep.

This study provided shocking evidence of the devastating effect of meth on our children. The children of alcoholics were said to have "thunderstorm" of problems, but the children of meth addicts suffer a "tornado" of trauma. They are at an extraordinary level of risk of mental health and substance abuse disorders.

Parents making the drug in their homes exposed their children to toxic fumes and the danger of explosions or fires. Some asked their children to steal items needed for making the drug or to stand guard, armed with a gun, looking out for police or other authorities.

Mr. Chairman, I've often spoken before about the tragic story of a young girl named Megan from a beautiful town in my home state of Minnesota.

Megan got started on meth when she was in the 7th grade at the age of 13.

One of her friends offered her the drug, and in her words, she liked meth so much that she knew she would do it again and again.

But when she couldn't afford her addiction, she, like too many other female addicts, was exploited into becoming a prostitute to pay for the meth she craved every second of the day.

After hitting rock bottom at the age of 18, Megan is managing to pull her life back together now after the 5 years meth stole from her.

But she has too much company in her treatment and addiction programs: about one in five of those treated for methamphetamine use in the state of Minnesota are 17 years old or younger.

As Members of Congress, in the face of so much suffering, we have an obligation to act.

The Methamphetamine Epidemic Elimination Act brings together a number of proposals made by many of our colleagues to fight this devastating scourge.

This legislation provides increased regulation of methamphetamine precursors, particularly pseudoephedrine; important tools to control the international superlabs; enhanced criminal penalties against methamphetamine kingpins and manufacturers; and greater attention to the environmental impact of domestic clandestine methamphetamine production labs.

I have worked with Representative Darlene Hooley of Oregon on many of the significant criminal penalties in this legislation in our bill, H.R. 3513, the Solutions to Limit the Abuse of Methamphetamine, or SLAM, Act.

We both believe that we must make sure that traffickers in meth are too scared by the prospect of long prison sentences to ever try to push this poison on our kids again.

Additionally, I can tell you from the experience of law enforcement in my home state of Minnesota, and in many other states dealing with the meth problem, local law enforcement spends roughly 80 percent of its time fighting small meth labs that produce only 20 percent of the meth on our streets. However, they lack the tools and resources to go after the source of the other 80 percent of the meth, international super labs.

Mr. Chairman, H.R. 3889 includes language I offered in an amendment to the FY06 State Department Authorization Act that was supported by the House International Relations Committee and 423 members of the House.

This language will bring some of the same weapons to bear on the international superlabs that produce methamphetamine that have proven successful and effective in controlling other natural drugs like heroin and cocaine.

This language serves to update, in an important way, our foreign policy to recognize the emergence of methamphetamine and other manufactured drugs.

Mr. Chairman, I thank you for holding this hearing here today, and I'd like to again thank the witnesses who agreed to come to speak about the ravages of methamphetamine.

I urge the swift passage of this important legislation.

Doing so will send a strong signal that Congress is serious about fighting the scourge of meth.

We must send a signal to the pushers of this poison that they are not welcome in our communities.

Most importantly, we must send a signal to the law enforcement officers who wake up every morning to protect our families that we stand with them in the fight against drugs and will work to give them every tool they need to be successful.

Thank You.

Mr. COBLE. Mr. Rannazzisi and Dr. Lester, you two have been placed in the bull's eye of the target, because both these guys beat the red light. So the pressure is on you. [Laughter.]

Mr. Rannazzisi, it's good to have you with us, sir.

TESTIMONY OF JOSEPH T. RANNAZZISI, DEPUTY CHIEF, OFFICE OF ENFORCEMENT OPERATIONS, U.S. DRUG ENFORCEMENT ADMINISTRATION

Mr. RANNAZZISI. Thank you very much, sir. Chairman Coble, Ranking Member Scott, and distinguished Members of the House Judiciary Committee, Subcommittee on Crime, Terrorism, and Homeland Security, on behalf of the Drug Enforcement Administration's Administrator, Karen P. Tandy, I appreciate your invitation to testify today regarding the DEA's efforts to combat the manufacture and distribution of methamphetamine and its precursor chemicals, in H.R.3889, the "Methamphetamine Epidemic Elimination Act."

Methamphetamine has swept across the country, and its devastating consequences are being felt throughout this nation by innocent children and adults, governmental agencies, businesses, and communities of all sizes. Methamphetamine found in the United States originates from two general sources, controlled by two distinct groups.

Mexico-based and California-based drug trafficking organizations control superlabs, and produce the majority of methamphetamine available in this country. The second source for methamphetamine comes from small toxic labs, which supplement the supply of this drug in the United States. Though these labs produce relatively small amounts of methamphetamine and are generally not affiliated with major drug trafficking organizations, they have an enormous impact on local communities, especially in rural areas.

A precise breakdown is not available, but current drug and lab seizure data suggests that roughly two-thirds of the methamphetamine used in the U.S. comes from larger labs, increasingly outside of the U.S., and that approximately one-third of the methamphetamine consumed in this country comes from the small toxic labs.

In an effort to combat methamphetamine, the DEA aggressively targets those who traffic in and manufacture this dangerous drug, as well as those who traffic in the chemicals utilized to produce it. We have initiated and led successful enforcement efforts focusing on meth and its precursor chemicals, that have dismantled and disrupted high-level methamphetamine traffic organizations, as well as dramatically reduced the amount of pseudoephedrine illegally entering our country.

We are also working with our global partners to target international methamphetamine traffickers, and have forged agreements to pre-screen pseudoephedrine shipments to ensure that they are being shipped to legitimate companies for legitimate purposes.

As a result of our efforts and those of our law enforcement partners in the U.S. and Canada, we have seen a dramatic decline in methamphetamine superlabs in the U.S. This decrease is largely a result of DEA's enforcement successes against suppliers of bulk shipments of precursor chemicals; notably, ephedrine and pseudoephedrine. Law enforcement has also seen a huge reduction in the amount of pseudoephedrine, ephedrine, and other precursor chemicals seized at the Canadian border.

We are also working closely with our State and local law enforcement partners to assist in the elimination of the small toxic labs that have spread across the country. The DEA administers the clean-up of the majority of meth labs seized in this country, with approximately 10,000 last year alone.

In an effort to further streamline the clean-up process and reduce costs, with the assistance of the Community Oriented Policing program, "COPS," in fiscal year 2004 we joined the Kentucky state police in initiating a container program. This container program has further reduced clean-up costs, and we plan to expand the program to other States during fiscal year 2006.

More than any other controlled substance, methamphetamine trafficking endangers children through the exposure of drug abuse, neglect, physical and sexual abuse, toxic chemicals, hazardous

waste, fire, and explosions. We are providing assistance to methamphetamine's victims through our Victim Witness Assistance Program. Through this program, the DEA's goal is to ensure that all endangered children are identified, and that the child's immediate safety is addressed at the scene by appropriate child welfare and health care providers.

In an effort to provide further information to America's youth about the dangers of methamphetamine, last month DEA launched a new website entitled "justthinktwice.com." This website is devoted to and designed by teenagers to give them the hard facts about methamphetamine and other illicit drugs.

The DEA also monitors State legislation aimed at combatting methamphetamine. It has noted the success experienced by some States in reducing the number of small toxic labs within their borders. The Administration strongly supports the development of Federal legislation to fight methamphetamine production, trafficking, and abuse.

Effective Federal legislation would include an individual purchase limit of 3.6 grams for transactions for retail sales of products containing pseudoephedrine; elimination of the blister pack exemption for pseudoephedrine products, thus requiring all products containing this substance to be subject to Federal law regardless of the packaging; and to prevent diversion of pseudoephedrine shipments for illegal use, a requirement that importers of pseudoephedrine request and receive approval from the DEA if there is a change to the shipment's original purchaser.

Thank you for your recognition of this important issue and the opportunity to testify today. I'll be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Rannazzisi follows:]

PREPARED STATEMENT OF JOSEPH T. RANNAZZISI

Chairman Coble, Representative Scott, and distinguished members of the House Judiciary Committee—Subcommittee on Crime, Terrorism, and Homeland Security, on behalf of the Drug Enforcement Administration's (DEA) Administrator, Karen Tandy, I appreciate your invitation to testify today regarding the "Methamphetamine Epidemic Elimination Act." I am pleased to testify here today.

OVERVIEW

Methamphetamine's devastating consequences are felt across the country by innocent children and adults, governmental agencies, businesses and communities of all sizes. More commonly known as "meth," this highly addictive stimulant can be easily manufactured using "recipes" available over the Internet and ingredients available at most major retail outlets. While meth used to be associated only with a few outlaw motorcycle gangs (OMG), the use and manufacturing of this deadly substance is now a national problem. Today, few communities in the United States have not been impacted by methamphetamine.

In an effort to combat methamphetamine, the DEA aggressively targets those who traffic in and manufacture this dangerous drug, as well as those who traffic in the chemicals utilized to produce it. We have initiated and led successful enforcement efforts focusing on meth and its precursor chemicals. Every day the DEA works side by side with our federal, state and local law enforcement partners to combat the scourge of meth. Last spring, DEA Administrator Tandy directed DEA's Mobile Enforcement Teams (MET) to prioritize methamphetamine trafficking organizations during their deployments. These and other initiatives have resulted in tremendously successful investigations, that have dismantled and disrupted high-level methamphetamine trafficking organizations, as well as dramatically reduced the amount of pseudoephedrine illegally entering our country.

In addition to our enforcement efforts, the DEA is combating this drug by administering the cleanup of labs across the country, providing assistance to the victims of methamphetamine and educating communities on the dangers of this drug. The DEA also monitors state legislation aimed at combating methamphetamine and has noted the success experienced by some states in reducing the number of small toxic labs within their borders. Additionally, the Administration supports the development of Federal legislation to fight methamphetamine production, trafficking and abuse. Any such legislation should of course balance law enforcement needs with the need for legitimate consumer access to widely used cold medicines.

METHAMPHETAMINE IN THE U.S.

Methamphetamine is a synthetic central nervous system stimulant that is classified as a Schedule II controlled substance. It is widely abused throughout the United States and is distributed under the names "crank," "meth," "crystal," and "speed." Methamphetamine is commonly sold in powder form, but has been distributed in tablets or as crystals ("glass" or "ice"). Methamphetamine can be smoked, snorted, injected or taken orally. The clandestine manufacture of methamphetamine has been a concern of law enforcement officials since the 1960's, when OMGs produced their own methamphetamine in labs and dominated distribution in the United States. While clandestine labs can produce other types of illicit drugs such as PCP, MDMA, and LSD, methamphetamine has always been the primary drug manufactured in the vast majority of drug labs seized by law enforcement officers.

STATE APPROACHES TO CONTROL METHAMPHETAMINE

As was discussed in the Interim Report from the National Synthetic Drugs Action Plan, the only two states that had enacted legislation from which we had reliable data at the time, were Oklahoma and Oregon. During April 2004, Oklahoma enacted the first and at that time, the most far-reaching state law restricting the sale of pseudoephedrine products. To date, over forty States have enacted or proposed various laws to restrict the sale of pseudophedrine products. This law made pseudoephedrine a Schedule V Controlled Substance in Oklahoma. Provisions of this law included: limiting sales of both single-entity and combination pseudoephedrine products to pharmacies; requiring pseudoephedrine products to be kept behind the pharmacy counter; and requiring the purchaser to show identification and sign a log sheet.

Oklahoma's law was noted in the National Synthetic Drugs Action Plan and was the first of many similar proposals introduced in State legislatures this past year. The Interim Report of May 2005 again noted Oklahoma's law, as well as Oregon's approach. In October 2004, Oregon adopted a similar approach to Oklahoma's model through a temporary administrative rule. Oregon, unlike Oklahoma, allowed combination pseudoephedrine products—those containing pseudoephedrine plus other active medical ingredients—to be sold at stores other than pharmacies, provided that the products were kept in a secure location. At the time of the Interim Report's release, only four months of data from Oregon were available for review. This review showed an approximate 42 percent reduction in the number of labs seized from the same months in the prior year. A review of 12 months worth of data from Oklahoma showed a 51 percent reduction in lab seizures (April 2004 through March 2005).[1]

The Interim Report noted that, even with the stabilization in methamphetamine laboratory numbers observed nationally, no states with consistently significant numbers of methamphetamine labs have seen the reductions in lab numbers that Oklahoma and, to a lesser but still significant extent, Oregon had seen. The Interim Report stated that, with the available data—a year's worth of data from Oklahoma, four months of data from Oregon, and several years worth of national data—strongly suggested that Oklahoma's and Oregon's state-level approaches were probably primary reasons for the dramatic reduction in the number of small toxic labs (STL) in Oklahoma, as well as smaller reductions in Oregon. It should also be noted that since the release of the Interim Report, Oregon has enacted legislation that made pseudoephedrine a Schedule III Controlled Substance.

Since the release of the Interim Report, the seizure of meth labs in Oklahoma has continued to remain at low levels, with a total of 115 meth labs being seized from April through July 2005.[2] The seizure of these 115 labs is significantly less than

[1] p.6, Interim Report.
[2] Oklahoma Bureau of Narcotics and Dangerous Drugs, August 2005.

the seizures reported in Oklahoma during this same time period in 2004 (261) and 2003 (423).

Furthermore, the State of Oregon has recently enacted legislation that classifies pseudoephedrine as a Schedule III Controlled Substance. This law is not scheduled to fully go into effect until July of 2006, so data does not yet exist to draw any conclusions as to its effectiveness.

METHAMPHETAMINE THREAT ASSESSMENT AND TRENDS

Methamphetamine found in the United States originates from two general sources, controlled by two distinct groups. Most of the methamphetamine in the United States is produced by Mexico-based and California-based Mexican drug trafficking organizations. These drug trafficking organizations control "super labs" and produce the majority of methamphetamine available throughout the United States. Mexican criminal organizations control most mid-level and retail methamphetamine distribution in the Pacific, Southwest, and West Central regions of the United States, as well as much of the distribution in the Great Lakes and Southeast regions. Mexican midlevel distributors sometimes supply methamphetamine to OMGs and Hispanic gangs for retail distribution throughout the country.

Asian methamphetamine distributors (Filipino, Japanese, Korean, Thai, and Vietnamese) are also active in the Pacific region, although Mexican criminal groups trafficking in "ice methamphetamine" have supplanted Asian criminal groups as the dominant distributors of this drug type in Hawaii. OMGs distribute methamphetamine throughout the country, and reporting indicates that they are particularly prevalent in many areas of the Great Lakes region, New England, and New York/New Jersey regions.

The second source for methamphetamine comes from STLs, which supplement the supply of methamphetamine in the United States Initially found only in the most Western States, there has been a steady increase and eastward spread of STLs in the United States. Many methamphetamine abusers quickly learn that the drug is easily produced and that it can be manufactured using common household products found at retail stores. For approximately $100 in "materials," a methamphetamine "cook" can produce approximately $1,000 worth of this poison. Items such as rock salt, battery acid, red phosphorous road flares, pool acid, and iodine crystals can be used as a source of the necessary chemicals. Precursor chemicals such as pseudoephedrine can be extracted from common, over-the-counter cold medications, regardless of whether it is sold in liquid, gel, or pill form. Using relatively common items such as mason jars, coffee filters, hot plates, pressure cookers, pillowcases, plastic tubing and gas cans. A clandestine lab operator can manufacture meth almost anywhere without the need for sophisticated laboratory equipment.

Widespread use of the internet has facilitated the dissemination of technology used to manufacture methamphetamine in STLs. This form of information sharing allows wide dissemination of these techniques to anyone with computer access. Aside from marijuana, methamphetamine is the only widely abused illegal drug that is capable of being produced by the abuser. Given the relative ease with which manufacturers are able to acquire "recipes" and ingredients, and the unsophisticated nature of the production process, it is not difficult to see why this highly addictive drug has spread across America.

STLs produce relatively small amounts of methamphetamine and are generally not affiliated with major drug trafficking organizations. However, STLs have an enormous impact on local communities, especially in rural areas.

A precise breakdown is not available, but current drug and lab seizure data suggests that roughly two-thirds of the methamphetamine used in the United States comes from larger labs, located outside the United States, and that approximately one-third of the methamphetamine consumed in this country comes from the small, more toxic laboratories.

BATTLING METHAMPHETAMINE AND ITS PRECURSOR CHEMICALS

As a result of our efforts and those of our law enforcement partners in the U.S. and Canada, we have seen a dramatic decline in methamphetamine super labs in the U.S. In 2004, 55 super labs were seized in the United States, the majority of which were in California. This is a dramatic decrease from the 246 super labs seized in 2001. This decrease is largely a result of DEA's enforcement successes against suppliers of bulk shipments of precursor chemicals, notably ephedrine and pseudoephedrine. Law enforcement has also seen a huge reduction in the amount of pseudoephedrine, ephedrine, and other precursor chemicals seized at the Canadian border.

More than any other controlled substance, methamphetamine trafficking endangers children through exposure to drug abuse, neglect, physical and sexual abuse, toxic chemicals, hazardous waste, fire, and explosions. An appalling example of methamphetamine-related abuse was discovered by the DEA in Missouri during November 2004. During an enforcement operation targeting a suspected methamphetamine laboratory located in a home, three children, all less than five years of age, were found sleeping on chemical-soaked rugs. The residence was filled with insects and rodents and had no electricity or running water. Ironically, two guard dogs kept by the "cooks" to fend off law enforcement were also found: clean, healthy, and well-fed. The dogs actually ate off a dinner plate.

Since being implemented in 1992, the DEA has enhanced its Victim Witness Assistance Program, and each of our Field Divisions now has a Victim/Witness Coordinator to ensure that all endangered children are identified and that the child's immediate safety is addressed at the scene by appropriate child welfare and health care providers. Assistance has also been provided to vulnerable adults, victims of domestic violence, and to customers and employees of businesses such as hotels and motels where methamphetamine has been produced or seized.

We also provide training on drug endangered children to federal, state, and local law enforcement and to national, state and local victim organizations. The DEA serves as a resource for child protective service and school social workers, first responders, mail carriers, and utility company personnel, all of whom may come in contact with labs and victims. To provide the public with current information on methamphetamine and drug endangered children, the DEA participates in numerous local, state, and national conferences and exhibits. The issue of victim services is included as part of our Basic Agent Training, and also is presented to our management across the country.

We have continued to investigate, disrupt and dismantle major methamphetamine trafficking organizations through the Consolidated Priority Organization Target (CPOT) list and our Priority Target Organization (PTO) investigations. The DEA is also significantly involved in the Organized Crime Drug Enforcement Task program (OCDETF) and we continue to work with state and local law enforcement agencies across the country to combat methamphetamine. Additionally, in March 2005, Administrator Tandy directed the DEA's MET teams to prioritize methamphetamine trafficking organizations during their deployments.

In an effort to provide further information to America's youth about the dangers of methamphetamine, on August 30, 2005, the DEA launched a new website entitled "justthinktwice.com." This website is devoted to and designed by teenagers to give them the hard facts about methamphetamine and other illicit drugs. Through this website, the DEA is telling teens to "think twice" about what they hear from friends, popular culture, and adults who advocate drug legalization. Information is also provided regarding the harm drugs cause to their health, their families, the environment, and to innocent bystanders.

The DEA also continues its work to ensure that only legitimate businesses with adequate chemical controls are licensed to handle bulk pseudoephedrine and ephedrine in the United States. In the past seven years, over 2,000 chemical registrants have been denied, surrendered, or withdrawn their registrations or applications as a result of DEA investigations. Between 2001 and 2004, DEA Diversion Investigators physically inspected more than half of the 3,000 chemical registrants at their places of business. We investigated the adequacy of their security safeguards to prevent the diversion of chemicals to the illicit market, and audited their recordkeeping to ensure compliance with federal regulations.

The DEA is also working with our global partners to target international methamphetamine traffickers and to increase chemical control efforts abroad. The DEA has worked hand in hand with our foreign law enforcement counterparts and have forged agreements to pre-screen pseudoephedrine shipments to ensure that they are being shipped to legitimate companies for legitimate purposes. An example of our efforts in this area is an operation worked with our counterparts from Hong Kong, Mexico and Panama, which prevented approximately 68 million pseudoephedrine tablets from reaching "meth cartels." This pseudoephedrine could have produced more than two metric tons of methamphetamine.

COMMENTS REGARDING THE "METHAMPHETAMINE EPIDEMIC ELIMINATION ACT"

As you can see, the DEA has known and has been working on the meth crisis for many years. We appreciate Congress' interest in this issue, and, without endorsing the specific legislative language of the bill, would like to offer some general observations regarding the "Methamphetamine Epidemic Elimination Act."

Title I—Domestic Regulation of Precursor Chemicals

This title repeals the federal "blister pack" exemption; reduces the federal per-transaction sales threshold for pseudoephedrine, ephedrine, and phenylpropanolamine products from 9 grams to 3.6 grams; and clarifies the law to include derivatives of each of these chemicals. The section also extends the Attorney General's existing authority to set import and production quotas, expands the existing penalties for illegal production and importation, and seeks to address a gap in our existing regulatory control system for imports and exports of pseudoephedrine.

As the Committee knows, the Administration strongly supports the development of Federal legislation to fight methamphetamine production, trafficking, and abuse. Effective Federal legislation would include an individual purchase limit of 3.6 grams per transaction for retail sales of over-the-counter products containing pseudophedrine; elimination of the blister pack exemption for pseudoephedrine products, thus requiring all products containing this substance to be subject to Federal law regardless of packaging; and, to prevent diversion of pseudoephedrine shipments for illegal use, a requirement that importers of pseudoephedrine request and receive approval from the DEA if there is a change in the shipment's original purchase. Additional controls on pseudoephedrine, however, must always be balanced against legitimate consumer access to affected products. A number of States have approached this challenge in different ways, taking into account their individual law enforcement and consumer access needs. As referenced above, early data indicate that several States which have done this through individual legislative and regulatory initiatives appear to have seen real and sustained reductions in the number of methamphetamine labs in their states. Denying methamphetamine cooks the ability to gather the ingredients they need, while balancing the need of law abiding citizens to be able to access these commonly used cold products, is an approach that works. We look forward to working with Congress.

Title II—International Regulation of Precursor Chemicals

This title would require additional reporting requirements for importers of ephedrine, pseudoephedrine, or phenolpropanolamine by requiring them to file additional information about the chain of distribution of imported chemicals. It also would place an additional reporting requirement on the State Department to identify the 5 largest exporters of major methamphetamine precursor chemicals, and the 5 largest importers that also have the highest rate of meth production or diversion of these chemicals to the production of meth. This title would incorporate these countries into the annual international counternarcotics "certification" process, and would make many forms of foreign assistance contingent on the President's certification that these countries are "fully cooperating" with the U.S. in enforcing chemical controls. (For chemical control efforts, the bill reverts to the stricter standard in effect before the 2002 certification cycle, after which the President designates only those countries that have "failed demonstrably" to cooperate.) Finally, the legislation would require the State Department's Bureau for International Narcotics and Law Enforcement Affairs to provide assistance to Mexico to prevent the production of methamphetamine in that country and to encourage Mexico to stop the illegal diversion of meth precursor chemicals.

We have serious concerns about these provisions. As you know, the Administration already reports on some of the information this language would require in the annual International Narcotics Control Strategy Report. Although we agree that diversion of precursor chemicals is a serious problem and that the annual counternarcotics "certification" process should do more to account for the actions of our foreign counterparts with respect to chemical control, we believe that there are more appropriate and plausible ways to achieve this overall goal. An inter-agency group coordinated by the Department of State, with the Department of Justice taking the lead in drafting, has also been addressing the problem of how to take better account of synthetic drugs and precursor chemicals in the certification process. We would like the opportunity to consult with the Committee as we address some of the same difficult issues you face in attempting to evaluate chemical commerce and countries' chemical control efforts.

In October 2004, the Administration released the *National Synthetic Drugs Action Plan.* In doing so, we proclaimed the seriousness of the challenges posed by methamphetamine—along with other synthetic drugs and diverted pharmaceuticals—and our resolve to confront those challenges. Part of the Action Plan specifically recognized the move of large labs outside the United States requires that we offer assistance to strengthen anti-methamphetamine activities. This, in turn, requires working with other countries known to suppling methamphetamine producers with illicit pseudoephedrine. A Synthetic Drugs Interagency Working Group (SD-IWG), co-chaired by the ONDCP and the Department of Justice, was directed to oversee im-

plementation of the Action Plan and to report to the ONDCP Director, Attorney General, and Secretary for Health and Human Services six months after the document's release. In the Interim Report, dated May 2, 2005, the SD-IWG responded to this portion of the Action Plan:

- China (particularly Hong Kong) has been a significant source of pseudoephedrine tablets that have been diverted to methamphetamine labs in Mexico. The United States and Mexico have obtained a commitment by Hong Kong not to ship chemicals to the United States, Mexico, or Panama until receiving an import permit or equivalent documentation and to pre-notify the receiving country before shipment.
- The United States has made significant progress in assisting Mexican authorities to improve their ability to respond to methamphetamine laboratories. The DEA has played a role by providing diversion and clandestine lab cleanup training courses for Mexican officials (both Federal and State).
- In conjunction with our joint efforts, Mexico this year began to impose stricter import quotas for pseudoephedrine, tied to estimates of national needs and based on extrapolations from a large population sample. Additionally, distributors have agreed to limit sales of pseudoephedrine to pharmacies, which in turn will sell no more than approximately nine grams per transaction to customers.

These developments stand as a model for the next steps to be taken with the limited number of manufacturers who produce bulk ephedrine and pseudoephedrine. Our efforts are, and will continue to be, focused on the primary producing and exporting countries for bulk ephedrine and pseudoephedrine: China, the Czech Republic, Germany, and India. Some of these efforts are not new, but involve a long-term commitment, using the tools at the Administration's disposal, to engage with foreign law enforcement and regulatory counterparts in these countries and to replicate the steps taken with Hong Kong and Panama. These steps include improving the sharing of information on pseudoephedrine shipments with other countries, thus preventing their diversion—especially to Mexico.

Under existing Federal law, the DEA must be notified if an ephedrine or pseudoephedrine product is destined for, or will transit through, the United States. But the legal and regulatory tools to limit imports and after-import distribution are relatively crude. Moreover, the prevailing interpretation of the 1988 United Nation's Convention that controls chemicals allows most finished pharmaceutical products containing pseudoephedrine in combination with other ingredients to be shipped in international commerce without pre-notification—a wide-open loophole that continues to be exploited by drug traffickers. The U.S., along with our Mexican and Canadian counterparts, has been working to gain international support for voluntary international cooperation to pre-notify shipments of these products; our efforts are being channeled through the drug control commission of the OAS ("CICAD").

Title IV—Enhanced Environmental Regulation of Methamphetamine By-Products

This title would give additional authority to the Transportation Department and the Environmental Protection Agency (EPA) to enforce environmental regulations against meth cooks who cause toxic pollution with meth by-products. In addition, this title would clarify existing law in light of the recent Eighth District Court of Appeals decision in *United States v. Lachowski* to allow the Federal government to seek restitution for environmental cleanup costs on persons involved in meth production and trafficking.

While the Administration cannot comment on the specific proposals in this title, the environmental costs associated with meth production have long been a concern of the DEA. In FY 1988, the DEA's Hazardous Waste Disposal Program was established to assist our Special Agents in the management of the chemicals, waste and contaminated equipment seized at clandestine drug laboratories. Funding for this program was initially provided through the Asset Forfeiture Fund. In 1998, the DEA began receiving funding from the Community Oriented Policing (COPS) program, and DEA Appropriated Funds in FY 1999, to support the cleanup of clandestine drug laboratories seized by state and local law enforcement. Together with the Asset Forfeiture Fund, these funding sources continue today.

Today, when a federal, state or local agency seizes a clandestine methamphetamine laboratory, EPA regulations require the agency to ensure that all hazardous waste materials are safely removed from the site. To facilitate the removal of these materials, the DEA awarded the first private sector contracts in 1991for hazardous waste cleanup and disposal. This program promotes the safety of law enforcement personnel and the public by using qualified companies with specialized training and equipment to remove hazardous waste seized at clandestine drug laboratories.

These contractors provide response services to DEA, as well as state and local law enforcement officials nationwide. These contracts serve communities by removing the source-chemicals that may pose threats to the public, which also helps to protect the environment.

Since the DEA first began using contractor services in the early 1990s, the number of cleanups has skyrocketed, though the average cost per cleanup has greatly decreased. The average cost per cleanup during the initial contract was approximately $17,000. During FY 2002, the average cleanup cost dropped to approximately $3,300, and currently, the average cost per cleanup is approximately $2,000.

To further reduce the cost of lab cleanups, in FY 2004, the DEA, with assistance provided by COPS, joined the Kentucky State Police to establish a pilot, clandestine lab "container program" in Kentucky. The program allows trained Kentucky law enforcement officers to safely package and transport hazardous waste from the clandestine laboratory sites to a centralized secure container that meets all hazardous waste storage requirements. The waste is subsequently kept in the container until it can be removed by a DEA contractor. The container program has streamlined the laboratory cleanup process by enabling law enforcement officials to manage small quantities of seized chemicals more quickly and efficiently. As of the third quarter of FY 2005, the average cost of cleanup in this project was approximately $350. The DEA is currently working to expand this program to several other states.

CONCLUSION

Methamphetamine continues to take a terrible toll on this country. To combat this poison, the DEA is attacking methamphetamine on all fronts. Our enforcement efforts are focused not only on the large-scale methamphetamine trafficking organizations distributing this drug in the U.S., but also on those involved in providing the precursor chemicals necessary to manufacture this poison. The DEA is well aware of the importance of controlling the precursor chemicals necessary to produce methamphetamine and is working with our international counterparts to forge agreements to control the flow of these chemicals

We are also working closely with our state and local law partners to assist in the elimination of the small toxic labs that have spread across the country. The DEA's Hazardous Waste Program, with the assistance of grants to state and local law enforcement, supports and funds the cleanup of a majority of the laboratories seized in the United States. The DEA has also taken an active role in the Victim Witness Assistance Program to assist methamphetamine's victims educating communities about the dangers of meth and other illicit drugs.

Thank you for your recognition of this important issue and the opportunity to testify today. I will be happy to answer any questions you may have.

Mr. COBLE. Thank you, sir. We've been joined by the distinguished gentlelady from California, Ms. Waters. Ms. Waters, good to have you with us.

Ms. WATERS. Thank you.

Mr. COBLE. Dr. Lester.

TESTIMONY OF BARRY M. LESTER, PH.D., PROFESSOR OF PSYCHIATRY AND HUMAN BEHAVIOR AND PEDIATRICS, BROWN UNIVERSITY MEDICAL SCHOOL

Mr. LESTER. Chairman Coble, Chairman Sensenbrenner, Ranking Member Scott, Members of this Subcommittee, we're in a similar situation today with methamphetamine as we were in the mid-1980's with what became known as the cocaine epidemic. During that time, there was legitimate concern for the welfare of children born cocaine-exposed. Based on poor information, there was a rush to judgment that led to an overreaction by society that had negative consequences for women and children.

Many women were prosecuted; children were removed from their biological mothers; and families were broken up. As a result, the number of children in foster care reached an all-time high in the mid-1990's. Many children suffered emotional problems from multiple foster care placements. And this is what led to the 1997 pas-

sage of the Adoption and Safe Families Act, requiring permanent placement within 12 months of a child being removed from his or her biological mother.

After 20 years of research, we learned that the effects of cocaine were not nearly as severe as initially feared. In fact, when factors like other drugs and poverty are controlled, the effects are subtle. We're talking about three or four IQ points, slight increases in behavior problems. In fact, these effects are not very different from those of cigarette smoking during pregnancy.

We also learned that while there are most definitely drug-using women that are inadequate parents, there are also drug-using women who are competent parents, and that with treatment, families can be kept together.

Our understanding of addiction has also changed in the past 20 years. We know more about addiction as a disease, as a medical mental health issue, and a disease that can be treated. It's a complex disease with multiple mental health co-morbidities, so that women who use drugs also tend to have other mental health problems.

So the bad news is that addiction is complex and requires serious treatment dollars. The good news is that it is treatable, and if we take a treatment-oriented rather than a punitive approach, we can reduce the problem of drug addiction in the country. I don't see the treatment approach in this legislation.

We learned some real hard lessons as the cocaine story unfolded. And I'm concerned that we're making the exact same mistakes with methamphetamine that we made with cocaine, as suggested by recent media coverage, by the punitive nature of this bill, and the absence of treatment dollars.

Methamphetamine is a stimulant like cocaine. Research on the effects of prenatal methamphetamine exposure on child outcome are just beginning. The only longitudinal study that's being done so far is our NIH study. And so far, what we're finding is very similar subtle effects to the effects we saw with cocaine. Again, to give you a context for this: not very different than women who smoke cigarettes during pregnancy.

Does this mean it's harmless, or that it's okay for women to use meth during pregnancy, or that we should not treat the women or the children? Of course not. Drug use of any kind should be discouraged during pregnancy, and treated. We know from previous research that even these smaller effects can turn to larger deficits, if the parenting environment is not adequate. And it is also possible that there are drug effects that don't show up until children get to school.

What we need here is a more balanced approach, and one that will get at the root causes of drug addiction. Sending more people to prison for longer periods of time is not the answer. Our knowledge base is still evolving, and will continue to do so. But we know enough now to fight addiction with treatment and keep families together if possible.

So here are some specific suggestions. We need a national consensus on how to deal with issues like maternal drug use that does justice to state-of-the-art knowledge in research and treatment and

demonstrates a fair and unbiased attitude toward women with addiction and their children.

We need to improve access to treatment; develop and coordinate multidisciplinary treatment programs with interconnected services based on the needs of women, mothers, and children. Models of methamphetamine treatment are based on adult male models. There are no treatment models designed to meet the specific needs of women, pregnant women, or mothers. For example, we know from the cocaine experience that it doesn't do any good to tell a poor mother with four kids in tow that she has six different appointments in six different locations, without providing transportation and babysitting.

We need to develop systematic prevention efforts, both treatment and education. And this includes education to prevent the onset or continuation of drug use and treatment to prevent future problems due to drug use.

And we need to develop family treatment drug courts, with the goal of keeping custody or reunification whenever possible. Drug courts are a way of providing a "treatment with teeth" approach that includes rewards for compliance with treatment and sanctions for non-compliance with treatment.

In Rhode Island, we have a program called "VIP"—it stands for "Vulnerable Infants Program"—which includes a family treatment drug court. We say "vulnerable" to imply that these children are somewhat fragile, but not damaged. And of course, they are VIPs; they're very important people.

This is a voluntary "treatment with teeth" program that has already been successful. We have reduced the length of stay of drug-exposed babies in the hospital; increased the number of infants who are going home with their biological mothers, hence reducing the number in foster care; and increased the number of children being reunified with their biological mothers. We should consider waiving punishment for clients who agree to, and comply with, treatment.

In sum, we have made tremendous gains in our understanding of addiction and treatment in the past 20 years. We have the opportunity to keep families together today in ways that were not possible only a few years ago. I am very optimistic about our ability to reduce addiction and save future generations of children through treatment. It would be not only a missed opportunity, but also a step backward, to put all of our eggs in the punishment basket. Thank you.

[The prepared statement of Mr. Lester follows:]

PREPARED STATEMENT OF DR. BARRY M. LESTER

Chairman Coble, Chairman Sensenbrenner, Ranking Member Scott, Members of the Subcommittee, thank you for the opportunity to testify on H.R. 3889, the Methamphetamine Epidemic Elimination Act.

We are in a similar situation today with methamphetamine as we were in 20 years ago during the cocaine epidemic. During that time, there was legitimate concern for the welfare of children exposed to cocaine in the wbomb. But based on insufficient or inaccurate information, society rushed to judgment—an over-reaction that had negative consequences for women and children. Many drug-addicted women were prosecuted and children were removed from their care. Families split up. As a result, by the mid 1990s, the number of children in foster care reached an all-time high to over 500,000. Many of these children suffered emotional prob-

lems from multiple foster care placements. This lead to the 1997 passage of the Adoption and Safe Families Act, or ASFA, requiring permanent placement of a child within 12 months of being removed from his or her biological mother.

After 20 years of research, we learned that the effects of cocaine are not nearly as severe as initially feared. In fact, when factors like other drugs and poverty are controlled, the effects are subtle—IQ lowered by 3 to 4 points, a slight increase in behavior or attention problems. These effects are similar to those caused by cigarette smoking during pregnancy. Scientists also learned that while there are most definitely drug users who are inadequate mothers, there are also drug users who are competent mothers who, with treatment, can care for their children.

Our understanding of addiction has also changed in two decades. We know more about addiction as a disease—a medical condition that can be treated. Addiction is a complex disease with multiple mental health co-morbidities; Women who use drugs also tend to be depressed and anxious and may have even more severe mental health problems. So the bad news: Addiction is complex. The good news: Addiction is treatable. We can reduce the problem of drug addiction in the country. I don't see treatment addressed in this legislation.

We learned some hard lessons since the cocaine story unfolded. I am concerned that we are on the verge of making the same mistakes with methamphetamine that we made with cocaine, as suggested by sensational media coverage, the absence of federal treatment dollars—and the punitive nature of this bill.

Methamphetamine is a stimulant like cocaine and produces similar effects on neurotransmitters in the brain. Research on the effects of prenatal methamphetamine exposure on child outcome is just beginning. To my knowledge, my current research into the prenatal effects of methamphetamine is the only such project funded the national Institutes of Health. Children in our study are still infants. So we can't measure all the affects of this drug. But, so far, we are seeing the same kind of subtle changes with methamphetamine that we saw with cocaine. Again—to put this in context—not very different than what you'd see with cigarette smoking.

Does this mean methamphetamine is harmless? Is it acceptable for women to use the drug during pregnancy? Of course not. And we know from previous research—including research with cocaine-using mothers—that even small neurobehavioral effects can turn to larger deficits if parenting is not adequate.

What we need is a balanced approach—one that will attack the root causes of drug addiction. Sending more people to prison for longer periods of time is not the answer. We know enough now to fight addiction with treatment and, if possible, keep families together.

Here are some specific suggestions:

- Develop a national consensus on how to deal with maternal drug use that draws on current research and tested treatment strategies—and demonstrates a fair and unbiased attitude towards drug-addicted women and their children.
- Improve access to treatment and develop coordinated treatment programs with interconnected services based on the needs of women, mothers and children. Models of methamphetamine treatment are based on adult male models. None are designed to meet the specific needs of women, pregnant women or mothers. For example, we know from the cocaine experience that it does no good to tell a poor mother with four kids in tow that she has six different appointments in six different locations without providing transportation or baby-sitting.
- Develop systemic prevention efforts. This includes education to prevent onset or continuation of drug use as well as treatment to prevent future problems due to drug use.
- Develop Family Treatment Drug Courts with the goal of keeping custody or reunification whenever possible. Drug Courts are a way providing a "treatment with teeth" approach that includes rewards for compliance with treatment and sanctions for noncompliance with treatment. In Rhode Island, we have a program called VIP (Vulnerable Infants Program) which includes a Family Treatment Drug Court (FTDC). Vulnerable is meant to imply that these children are somewhat fragile but not damaged and of course they are **V**ery **I**mportant **P**eople. This is a voluntary "treatment with teeth" program that has been successful. We have reduced the length of stay of drug-exposed babies in the hospital, increased the number of infants who are going home with their biological mothers (hence reducing the number in foster care) and increased the number of children being reunified with their biological mothers. We should consider waiving punishment for clients who agree to and comply with treatment.

In sum, we have made tremendous strides in 20 years when it comes to understanding drug addiction and treatment. We have the opportunity to keep families together today in ways that were not possible only a few years ago. I am very optimistic about our ability to reduce addiction and save future generations of children through treatment. It would be not only a missed opportunity, but a major step backward, to put all of our eggs in the punishment basket.

Mr. Chairman, thank you again for the opportunity to testify here today. I would be happy to answer any questions.

Mr. COBLE. Thank you, Dr. Lester. And thanks to each of you for your testimony. Gentlemen, we impose the 5-minute rule against ourselves as well, so if you all could keep your answer as terse as possible it would enable us to move along.

Mark—We've got two "Marks." Mr. Souder, you touched on this very briefly, but I want to revisit it. The Talent-Feinstein proposal listed pseudoephedrine as a Schedule V drug under the Controlled Substances Act, and restricts monthly sales to individuals. Why did you not include it in your bill?

Mr. SOUDER. We tried to deal with the question of blister packs and quantity purchase. We're silent on that. That way, it could be merged with this. But let me say what my personal opinion is; which does not necessarily represent the group of sponsors on the bill, because it's silent on this subject.

Meth, unlike crack and other things, has not covered the whole country. Even in my district, it's in the rural areas and some of the small towns, but not in the city of Fort Wayne, of 200,000, or in Elkhart, of 45,000. It's nowhere near the East Coast. It may get there as it moves east, and it may go into the cities.

But it means that shutting down pseudoephedrine products, cold medicines, for everybody in the United States doesn't make much sense, in my opinion. Certainly, in rural areas where they don't have pharmacies in a lot of the grocery stores, in effect, you'll pull all the profitability of the grocery stores out and you'll shut them down. In these little markets in New York City and in Los Angeles, in big cities, you take all the cold medicines out. That's part of the profit of these stores, and you're depriving consumers when they don't have a meth problem.

Now, I believe that you should get at it at the wholesale level. Where you see it go up, we should try to address that. But I believe we're taking a big stick to whack a problem that is isolated—growing; it's a threat; but if we need to do that, if it becomes national, then we do it. I don't favor it at this point, and I think we need to look for something that's a more complex, diversified approach, than a simplistic answer.

Mr. COBLE. All right, thank you, Mark.

Dr. Lester, let me put a three-part question to you. How successful are drug treatment programs for meth abuse, A? What types of drug treatment programs work and what types do not work, B? And finally, C, how addictive is meth, as compared to other drugs?

Mr. LESTER. There are methamphetamine programs that are successful. Probably, the best well-known one is called the "Matrix" program, which was developed out in California. I think the problem with all of the methamphetamine programs, including Matrix, is that they were pretty much developed on adult male models. So again, they don't deal with special populations like women and mothers, and certainly pregnant women.

So I think the ideal situation would be to take some of the models that have been developed for cocaine and methamphetamine and reorganize them for special populations. And I think we also need to get them combined with family treatment drug courts; what would be, you know, a whole package to go.

What types of programs work? The kinds of programs that work are programs that are comprehensive, that are family based—in other words, that treat the whole family. You know, for example, if you treat the mother and put her back in the home where her husband or her boyfriend is using, that's not going to do any good.

They have to be comprehensive, and treat the mental health comorbidities that go along with substance abuse. So comprehensive programs are critical. And the programs that do not work are the kind of one-shot, you know, just going after one aspect of the problem, and ignoring everything else.

Mr. COBLE. How about the addictive? Is it more addictive than other drugs, or how does it compare with other drugs?

Mr. LESTER. It's more psychologically addictive than a lot of other drugs. It's not necessarily physiologically addictive. I mean, it's psychologically addictive like cocaine, maybe even a bit more, depending on the nature of the user.

Mr. COBLE. Thank you, sir.

I think I have time for one more question. Mr. Rannazzisi, what tools would assist the DEA in increasing enforcement actions against the larger meth traffickers and the Mexican superlabs?

Mr. RANNAZZISI. Well, there's a variety. Again, we're treating these cases just like we treat normal drug cases. We're going after the larger organizations. That being said, since there's two components here, we're looking at both the small labs, trying to deal with that, and also the large Mexican organizations.

We have the CPOT program, and we're targeting these large, major organizations, these principals that are running these drug organizations, through that program. However, you know, again, we have to go back to what we need legislatively.

I think that the Administration, through Secretary Leavitt, AG Gonzales, and Mr. Walters from ONDCP, laid out what we need legislatively to help us along with this case: the 3.6-gram limit on purchases; the elimination of the blister pack exemption that, you know, has been dogging us for years now; and also, removal of the chemical spot market loophole.

The chemical spot market loophole is, basically, killing us. What happens is, in the spot market, if an importer brings drugs—an importer sets up to import a certain amount of pseudoephedrine, say, for two or three companies. He gets permission from DEA. Over a 15-day period, we give him permission for those particular downstream customers.

Now, when the drugs come in, or the pseudoephedrine comes in, at that point in time, if he loses one of those customers, he could sell it to anybody, and DEA is not aware of it. That's the spot market loophole. It could go to any distributor, anywhere in the U.S. So what we're asking for is to close up that loophole. That's the tools we need.

Mr. COBLE. Thank you, sir. My time has expired.

The distinguished gentleman from Massachusetts, Mr. Delahunt.

Mr. DELAHUNT. Yes. Thank you, Mr. Chairman. I want to compliment the DEA for the good work that they do. I also want to compliment my colleagues, Mr. Kennedy and Mr. Souder. I know that their commitment is outstanding in terms of dealing with this particular issue.

Let me tell you what my problems are. I don't see anything about treatment in here. Okay? Secondly, we've been down the road before of mandatory sentences. I think it was you, Mr. Kennedy, that alluded to sending messages. We've been sending messages.

I think it should be by now conclusive evidence that just simply enhancing penalties is in no way going to reduce the trafficking in a particular controlled substance. You know, in 1988, there was legislation. I think that was the year that created the 5- and 10-year minimum mandatories. In 1996, I believe it was—the threshold amount was reduced. We're going back to do the same thing again.

You know, I'm convinced that if we're going to do something significant and substantial, we have to look at the treatment paradigms, and make some choices in terms of our funding. There's no reference in the legislation about treatment. I mean, the demand—you've got to attack this on the demand side.

Deterrence, I'm not saying that we don't have to have penalties. Clearly, we have to have significant sanctions. But we've been down that route. And now we have an epidemic. We didn't have the epidemic in 1988 and 1996. Now it's an epidemic, as described in the title of this bill.

There is a program, I understand, out in Orange County that requires a minimum of an 18-month treatment program, and whoever graduates from it must be drug free for a period of 180 days, must be employed, must have his or her act together.

What about Professor Lester's observation about there are some successful programs dealing with adult males now, and expanding that to all different subsets of the addict population? Congressman Souder.

Mr. SOUDER. May I respond?

Mr. DELAHUNT. Please.

Mr. SOUDER. Several things. First off, this is—we're doing a series of meth bills and a series of amendments. These are different appropriations. This is the Judiciary Committee. It has to be targeted to judiciary things. To go on Frank Wolf's Appropriations Subcommittee, which is where this may be attached, it had to be relevant to that appropriations bill; therefore, it doesn't address that.

I believe this does not add mandatory minimums. In fact, we changed it to make sure we held bipartisan support. We did lower the thresholds because meth—unlike crack and unlike heroin, these people are producing and selling simultaneously. It's a different type of a drug than anything else we're dealing with.

Now, in the treatment question, first off, I don't disagree that we need to do more. And we need to be looking at the Labor-HHS bill to address that. We need to be targeting things inside that on meth. Charlie Curie, the head of SAMHSA, was in my district. We've met with different treatment providers.

I strongly disagree with the statements—some of them—earlier; I agree with some of the conclusions. There is no adult male meth treatment. He's talking about cocaine and heroin. I don't think he's got that much experience with meth.

The Matrix model isn't working in meth. They're trying to get it to work, but you have the mom, the dad, their whole group. There's not like an enabler, a support group, to put them back.

We need to be targeting funds in HHS, and drug treatment funds. We need to increase drug courts. We've heard that drug courts work because if you have a law and enforcement, then they'll go to treatment. And we need to make sure there are treatment dollars there.

This is a law enforcement bill. We need to look at how to take this Matrix model where—you know one other problem? In these rural areas, they can't do the Matrix model because they don't have enough dollars to pay a staff-level person who's experienced enough even to test the Matrix model in these mom-and-pop labs.

I don't disagree with you at all on treatment. I support more dollars for treatment. I support legislation for that. I've co-sponsored legislation for that. That's not what this is.

Mr. DELAHUNT. Just reclaiming my time for 1 minute, you know, what concerns me is that a bill would come from this Committee with these mandatory minimums, and nothing will happen on the treatment side. What I would suggest to you, in terms of expanding your base of support, that there be an omnibus bill to be presented to the Committee, including and implicating treatment.

Whether the Matrix program works or not, I don't know. But I do know this. Okay? By cutting the threshold amounts, it's the same thing as expanding the minimum mandatory sanction. And it hasn't worked. It just won't work.

You know, mandatory treatment—mandatory treatment—should be a concept that I would suggest should be introduced into this kind of legislation; rather than just simply a mandatory minimum prison sentence. Mandatory treatment is something that I dare say would receive widespread support.

Yes, you do need those triggers, and you need those sanctions. Oftentimes, people will not come voluntarily to these potential treatment programs unless there is some sort of coercion. But that's the direction we ought to be going in.

Mr. COBLE. I thank the gentleman.

The distinguished gentleman from Florida, Mr. Feeney.

Mr. FEENEY. I thank the Chairman. And I want to congratulate my colleagues, Congressman Souder and Congressman Kennedy, for tackling a major national problem that seems to be expanding very rapidly.

One question I have for any of the panel is related to the demographics. On page 3 of our memorandum, the Members here have an indication that, of the Federal offenders, something like 60 percent of the offenders are white, 33 percent are Hispanic, and only 2 percent are African American. Do you have any explanations or theories as to the disproportionately high level of Caucasians and disproportionately low level of African Americans that have been convicted of Federal offenses?

Mr. SOUDER. If I can take a quick stab at that, based on our regional field hearings, I've asked the same question in multiple locations across the country. It appears that it is in the rural areas where you see the mom-and-pop labs, which are the easiest ones to arrest because they tend to blow up their families, tend to pollute the rivers. So they come into law enforcement quicker than those who are from the superlabs and the crystal meth—they tend to be disproportionately white. The rural areas are disproportionately white. They start off in a motorcycle gang, spread into the community, and are heavily white.

When you see the superlab organizations come in, even in the rural areas, they're predominantly Hispanic; but they're still selling meth. It's predominantly a rural, and increasingly a suburban, phenomenon.

Omaha and Minneapolis/Saint Paul are the two big cities that have been hit. I asked the U.S. Attorney and the State Director in Minneapolis, when we were up there in Saint Paul at Congressman Kennedy's request, why we didn't see meth in the African American community. And he said because the traditional distribution methods are with cocaine in the major cities, and/or heroin; not meth.

But in one neighborhood in Minneapolis, one of the distribution groups moved over to meth. And in that area, in 3 months, 20 percent of the people arrested in that community—the whole community—were meth, because that one neighborhood switched over, because the local gang realized they could cut out the Colombians and just work with the Mexican superlabs with meth.

That's why I believe this is a potential epidemic that's going to destroy Los Angeles, Chicago, Detroit, Boston, and other cities, if it gets into the larger urban communities.

Even in my home town of Fort Wayne, which is 230,000, we have had one lab, and around it—we are fifth-largest in the nation, but it hasn't come into the city because the distribution network is cocaine and heroin.

Mr. FEENEY. Doctor? And by the way, could you address—I asked the question based on ethnic demographics, but I'd also be interested based on economic demographics. Are we largely talking about, you know, poor people? Or is this an exotic, you know, drug in the Wall Street and Hollywood——

Mr. LESTER. Sure you want to know? I can only speak from our ongoing NIH study. In that study, the places where we're doing this research are Oklahoma, Iowa, southern California, and Hawaii. And the demographics that we're seeing are pretty much what you described: very, very few black; mostly Caucasian and Hispanic.

We're looking into that because we don't, you know, quite understand it. What we've been hearing is that a lot of it is cultural; that for some reason, you know, cocaine seems to be—you know, cocaine seems to be confined to, you know, black, inner-city, poverty populations; and meth seems to just be more popular with—not so much strictly poverty, but a lot of blue-collar workers, a lot of, you know, farm people, factory workers. And not necessarily poor; it's working people.

Mr. FEENEY. Okay, Doctor. But what do you think of Mr. Souder's theory? He's got a very good control group of African Americans. His theory is that it's—based on the evidence that he's heard—is that the use disparity is because of the distribution networks; and once you infiltrate the distribution network of the traditional cocaine users, that the African American community—this problem will mushroom as well.

Mr. LESTER. We haven't seen that. What we've heard is that, for whatever cultural reasons, the inner-city African Americans don't like it. They just—they prefer cocaine.

Mr. FEENEY. Well, let's hope that's true. Finally, either for my good friend——

Mr. LESTER. Why would you hope that's true?

Mr. FEENEY.—Mr. Kennedy or Mr. Souder, on the 10th amendment issue, I have concerns about federalizing every crime. This doesn't actually add any new crimes; although it does lower some of the thresholds. Is that right?

Mr. KENNEDY. It does lower the thresholds. Where we give the ability to add an additional penalty is when they're using these expedited entry programs coming in from Mexico; which is distinctly a Federal issue.

Mr. FEENEY. The import-export I have no problem with.

Mr. KENNEDY. So we want to make sure that we're keeping commerce going back and forth between Mexico and America, Canada and America. So when they use those sort of, you know, "You're clean, we'll let you through quicker," and then bring meth in, we want them to have an extra penalty. And I think that is a Federal role.

Mr. FEENEY. I'm out of time. It's up to the Chairman, Dr. Lester.

Mr. COBLE. I didn't see the red light. The distinguished gentleman from Virginia.

Mr. SCOTT. Thank you, Mr. Chairman. Dr. Lester, do I understand that you treat pregnant women that may be drug addicted with meth?

Mr. LESTER. Well, in Rhode Island, we don't have much meth; so mostly, we treat cocaine users. We are seeing some of the meth users in our other studies.

Mr. SCOTT. Well, in the other studies, I assume your interest is to reduce the drug use, just a straight—that's your interest. And in that interest, what is the medical protocol to reduce the drug use? Is it to turn the pregnant woman over to the police, or to start a prevention treatment protocol?

Mr. LESTER. This is not a treatment study, so what we're doing is looking at the effects of prenatal methamphetamine exposure on the development of the children. So we're not providing treatment.

Mr. SCOTT. Well, what would be the protocol to deal with the problem?

Mr. LESTER. Well, the protocol that we would use would be the one that we're using in Rhode Island for the cocaine using mothers, which is our VIP program, where we identify the patients in the hospital, present the voluntary treatment part to them and lay out a treatment plan, and then develop a treatment plan and get them to sign up for it. And if they do, then they get to either keep their baby or, if the baby has already been removed, they get reunified.

Mr. SCOTT. But the focus with the goal of reducing drug use would be treatment, not incarceration?

Mr. LESTER. Oh, absolutely. No, I mean, the whole idea would be that if you can reduce the addiction, then you're going to reduce the need for drugs, right? And also, you know, since we work with children, our firm belief is that you would then prevent children from growing up in drug environments, and perhaps reduce the prevalence of drug users in the next generation.

Mr. SCOTT. Thank you. Mr. Rannazzisi, for 5 grams of crack cocaine you get 5 years mandatory minimum. To get the 5 years mandatory minimum, you've got to get up to 500 grams of powder. Is that right?

Mr. RANNAZZISI. Yes, I believe that's correct; five and five, yes.

Mr. SCOTT. Is there any evidence that people use powder rather than crack cocaine because of the disparity in sentencing where you can get probation versus 5 years mandatory minimum?

Mr. RANNAZZISI. I don't necessarily if our users use the statutory minimums as a deterrent. I think it's their personal choice, whatever drug they want to use.

Mr. SCOTT. Right. And the fact that you can get probation for one or 5 years mandatory minimum doesn't really enter into the calculation. They're both illegal. So you did not reduce the incidence of crack use by having a draconian 5-year mandatory minimum sentence; did you?

Mr. RANNAZZISI. Putting it that way, I guess not.

Mr. SCOTT. Okay. Let me ask you another question. You were talking about 3 grams of meth to trigger the Federal mandatory minimums in this bill?

Mr. RANNAZZISI. I just briefly read the bill, and I believe that was 3 grams, yes.

Mr. SCOTT. Okay.

Mr. RANNAZZISI. Three-point-five.

Mr. SOUDER. It's intent to distribute; not for usage. Possession doesn't do it; it's intent to distribute.

Mr. SCOTT. Well, if you've got it and you've got friends, you pretty much can—have you got a problem, if you've got somebody with a requisite amount, busting them for distribution, if they've got friends and they kind of use it together?

Mr. RANNAZZISI. I believe that would be up to the U.S. attorney to make that decision.

Mr. SCOTT. How much is a weekend's worth of meth? How much does that cost, and how many grams is it? If somebody just wanted to get high over the weekend, how much would they be buying?

Mr. RANNAZZISI. Well, that would be up to the user. You know, usually, they buy in grams or half-grams. It's usually three to five hits per gram. And it just depends. Remember, methamphetamine keeps you high, or keeps you up, a lot longer than cocaine does; so, you know, depending on the user, how long he's used it, he could be up for—you know, two or three hits could keep him up all day, maybe into the next day. It just depends on the user and the tolerance of the user for the drug.

Mr. SCOTT. For a user, 3 grams, how long would that last? I mean, would it be a month's worth?

Mr. RANNAZZISI. No, it wouldn't be a month's worth. Probably—probably, two, three, maybe 4 days, if he's a regular user, and if he's not sharing.

Mr. SCOTT. Wait a minute. Three grams would be a couple of days worth?

Mr. RANNAZZISI. Three, maybe 4 days, yes. It depends on how many hits he's taking. It depends on the amount he's using for one hit.

Mr. SCOTT. Well, we're just kind of getting a ball park figure to know what the trigger is for the mandatory minimums. My time is up. We're going to have another round, I believe. So, thank you.

Mr. COBLE. The distinguished gentlelady from California, Ms. Waters.

Ms. WATERS. Thank you very much, Mr. Chairman. I'd like to thank our panelists for being here today, and my colleague, Mr. Souder, for his interest in this area.

I don't know if you know, Congressmen, about all that we've been through with crack cocaine and mandatory minimum sentencing. In addition to the mandatory minimum sentencing, the conspiracy laws that work hand-in-hand have jailed an awful lot of folks in the black community, a lot of women who happen to be the mates or girlfriends of guys who get caught up in possession and sale of crack cocaine.

What's troublesome about crack cocaine is young people, 19 years old, who have never committed a crime before, who come from good families, who—you know, at the wrong place, the wrong time, the wrong crowd—with 5 grams of crack cocaine, end up in prison under mandatory minimum sentencing laws. And of course, the number of years increases with the amount in possession. And these young people, once they do 5 years in Federal penitentiary, probably will never work again. It's hard to get their lives together. Mandatory minimum sentencing has been devastating on the African American community.

I hear questions being asked about, "Why don't they use meth?" It's kind of a strange question, and I'm trying to figure out what that means. But the fact of the matter is, we have gone through heroin, PCP, crack, now meth. And meth is being talked about as the most devastating drug in the Midwest, with the whites, I suppose, falling prey to this devastation.

The fact of the matter is, whether it is crack or meth, you know, we have a drug problem in America, and it's not going to be solved with mandatory minimum sentencing. As a matter of fact, we exacerbate poverty and family separation and devastation to communities with these kinds of penalties.

What we don't want to talk about is the cost of dealing with drug addiction and the fact that we need treatment programs and we need a bevy of people who are trained, social workers who are trained, to be assigned to families, to keep up with them while they complete their treatments and see them into mainstream.

But that's just too much for us to talk about. And even though you say that treatment is dealt with in other places where it's more appropriate and they have the jurisdiction, and you come here to talk about trying to do something on the criminal justice side, I submit to you that those of us who have been working with the

Sentencing Commission and who have been working—I hold a workshop every year with the Congressional Black Caucus. And I have brought in hundreds of folks who have been the victims of mandatory minimum sentencing.

Judges don't like it. They hate it. I've written to every Federal judge who has responded, you know, "It's a problem that Congress created for us, and you need to do something about it."

So I can't in any way be helpful or supportive of anything that increases mandatory minimum sentencing. I'm very, very supportive of getting tough on superlabs, getting tough on incorrigible individuals who are intent on production—and I think there are some ways to do that—clearly identified as criminals.

But most of these young people, you're going to find, whether it's in Idaho or any of these other places, that end up in these parties or barns that go on all night with the use of meth, are not really criminals. And they need help, and they need treatment programs.

And if these young people end up in prison, with mandatory minimum sentencing—and you're reducing it from five to three—you're just creating another problem in our society for people who cannot get a job, cannot get student loans, cannot get section 8 programs. And they come back and they rob and they steal and they survive.

So I would ask you to look at this again, and rethink whether or not you want to deal with the mandatory minimum sentencing in this way. I think there's some room to deal with the precursors. I think there's some room to deal with the border. I mean, you know, come in here and talk to me about Vicente Fox, and what we're going to do with him and trade if they don't do something about transporting these drugs across the border from these superlabs in Mexico.

But to just, you know, talk about, you know, young people who use this meth and get high, going to penitentiary, does not do anything to make me believe that it's going to be helpful. I yield back the balance of my time.

Mr. GOHMERT. [Presiding.] Thank the gentlelady from California.

Mr. SOUDER. Mr. Chairman, may I briefly comment on what the bill says?

Mr. GOHMERT. Do you have any objections?

[No response.]

Mr. GOHMERT. All right, without objection, you may take 2 minutes.

Mr. SOUDER. Thank you. I appreciate the gentlelady's concern. This deals with distribution. I know Congressman Rangel, when he first did the crack cocaine mandatories, was trying to get ahead of the curve with it in New York City and elsewhere.

And you can argue about the power of crack, and whether that worked, but meth is different. The users are the cookers. We're talking here about home labs—home-type labs, not the crystal meth. And it's not kids. For the most part, this problem isn't kids. It's adults. And it is rural-wise, moving toward the suburban and urban areas.

Ms. WATERS. Where is your empirical data on all of this?

Mr. SOUDER. Oh, it's documented through drug court data, through DEA data. If you go in the only cities where they've had meth for 10 years, like Honolulu, it has moved into the cities. And

then it starts to look like any type of drug. But they're having—but what's different about a mom-and-pop lab is they're having to spend $300 to $400 in some apartment complexes to fumigate it, once it hits the city, because it endangers—the toxic chemicals endanger the next family coming in.

This is different than other types of drugs, and we have to understand it's going to take a different solution. I don't believe the solution here, personally, is more mandatory minimums for usage. I believe you do have to get into hardline positions on distribution and get control of this.

Ms. WATERS. But distribution is possession. So how much are you talking about in possession in order to trigger these reduced mandatory minimums?

Mr. SOUDER. It's also different than other drugs, because you do not get off easy, in the sense of you start with a light part—it's not something like marijuana, where you find casual users; or even crack or cocaine, where you find casual users; or heroin users, who can still function. Meth users tend to go straight down on a line, unless they go cold-turkey off it. It's different than other drugs.

Ms. WATERS. No, I want to tell you, we heard this about crack. It's supposed to be one hit, and you can never stop. So, you know, as each of these drugs are introduced into our public policy making, they're always described as one being more terrible than the other. They're all terrible.

Mr. SOUDER. Oh, I agree——

Ms. WATERS. They're all terrible.

Mr. GOHMERT. We've lost the organizational flow here. Did you yield? If you want to yield to the gentlelady from California, then that's how it would have to be, because it was your 2 minutes. But did you finish?

Mr. SOUDER. Yes.

Mr. GOHMERT. Okay, next—all right, then the chair yields 5 minutes to Mr. Scott.

Mr. SCOTT. Thank you. Mr. Rannazzisi, in manufacturing and distributing meth, how much of the price that the buyer pays is actual production cost, as opposed to distribution cost? Is it fair to say the cost of the product is de minimis in the overall transaction?

Mr. RANNAZZISI. I don't know, you're looking at $100—well, between $80 and $100 a gram, we'll say. Okay? Usually, the small labs are not making—you know, they're making an ounce. They're usually about a half-ounce, but they could make up to an ounce or two. It doesn't cost a lot to make the drug. Actually, it's very cheap to make the drug, extremely cheap to make the drug.

Mr. SCOTT. In the superlab, out of the $100, $80 to $100 you pay for the ounce, how much did they pay for product?

Mr. RANNAZZISI. You mean—I'm sorry, the gram. Eighty to $100 a gram.

Mr. SCOTT. Gram? Okay. Whatever—Okay, $80 to $100 a gram. How much of that went to the actual product cost?

Ms. WATERS. Five dollars.

Mr. SCOTT. Is it safe to say it's de minimis? I mean, it's meaningless.

Mr. RANNAZZISI. I wouldn't know. I wouldn't know to answer that question. It depends on how much they're paying for their materials, their raw materials.

Mr. SCOTT. Right.

Mr. RANNAZZISI. Exactly.

Mr. SCOTT. And the raw materials, in the overall cost of what you make, the overall cost of the materials would be essentially de minimis. I mean, the real stuff is the distribution, the risk of getting arrested, and all that. That's what you're paying for: distribution, not manufacturing. Is that right?

Mr. SOUDER. Mr. Scott, I agree with this: on the superlabs, it's almost all distribution. On the mom-and-pop, the price varies so much by area, and whether they're selling to their friends. Sometimes they're just selling it to purchase more materials to make it.

Mr. SCOTT. And with the mom-and-pop, they don't have the—what do you have?—the savings in volume, because they've got to buy the equipment. And if they just make a couple of ounces, all of their equipment and setup is spread over just a few ounces. Whereas, the superlab, that same cost would be spread over pounds.

Mr. SOUDER. The other minimal thing that we've heard—we haven't had a lot of meth addicts who've testified, but in talking to some of them and having their testimony, they don't appear to be able to hold a job shortly after becoming addicted. It's a fairly downward cycle relatively rapidly. So they try to replace income for their car, sometimes their house payments, with the sale.

Mr. SCOTT. Now, we're aimed at true kingpins. And is it true that the low-level guy caught up in the conspiracy will get charged with the whole operation? So if you had a corner guy, just passing it, and it's a million-dollar operation, he will be charged with the whole million dollars; is that right?

Mr. RANNAZZISI. Again, that's up to the United States attorney that reviews the case.

Mr. SCOTT. Can he do it? He can do it; is that right?

Mr. RANNAZZISI. The U.S. attorney would make that decision. If he feels he has enough evidence to do that prosecution——

Mr. SCOTT. If he's got a multi-million-dollar operation, everybody in the operation is on the hook to the multi-million-dollar threshold; is that right?

Mr. RANNAZZISI. Again, if the evidence proves that a person is involved in the conspiracy and can be culpable for that amount, the U.S. attorney makes that decision.

Mr. SCOTT. Culpable in the distribution, in the operation—your little, low-level operator in a multi-million-dollar operation. The fact is that when they say, "How much were you involved with?" in terms for threshold purposes, it's the whole ball of wax, all of it. Everybody gets charged with all of it; isn't that right? Excuse me, may be charged, at the discretion of the U.S. attorney.

Mr. RANNAZZISI. At the discretion of the U.S. attorney.

Mr. SCOTT. Okay. So we know it's possible.

Mr. RANNAZZISI. Yes, it is possible.

Mr. SCOTT. In terms of the import quotas for the chemicals, who gets to set what the quota will be? How much actually gets in?

Mr. RANNAZZISI. Well, since this is new, I can only speak for what we do as far as controlled substances. As far as controlled substances go, raw materials, we look at the national consumption.

Mr. SCOTT. Wait, wait a minute. Who is "we"?

Mr. RANNAZZISI. The Drug Enforcement Administration.

Mr. SCOTT. DEA?

Mr. RANNAZZISI. Yes.

Mr. SCOTT. Not FDA?

Mr. RANNAZZISI. The Drug Enforcement Administration.

Mr. SCOTT. Okay. There are legitimate uses for these chemicals; is that right?

Mr. RANNAZZISI. Absolutely. Yes.

Mr. SCOTT. Now, I mean, suppose the drug manufacturers, the cold remedy people, want more. Who gets to decide whether or not they can import the stuff?

Mr. RANNAZZISI. Well, are we talking an aggregate quota? They would have to provide justification for importing more. They'd have to provide justification. As we're setting up a quota system, justification has to—they have to provide justification for us to determine what the quota amount will be. They just don't give us a figure and we say, "Okay." There's got to be some justification.

Mr. SCOTT. Well, if I could, Mr. Chairman, is this quota——

Mr. GOHMERT. The Chair will yield an additional minute.

Mr. SCOTT. Thank you. Is this quota per transaction? I mean, you just kind of make it up as you go along? Or is there a national quota, that so much can come in? Or you kind of regulate it piece by piece? How would that work?

Mr. RANNAZZISI. I can only speak for controlled substances, but when we have raw material quotas on controlled substances, it changes year to year, depending on the legitimate need of the——

Mr. SCOTT. Is this an aggregate quota for the country?

Mr. RANNAZZISI. For the country, absolutely, yes.

Mr. SCOTT. Okay. And then who gets it? I mean, does Merck get it, and Eli Lily can't get it?

Mr. RANNAZZISI. For controlled substances we take each individual company, each individual company that requests a need for a particular raw material. And when we look at all the companies together, that's how we determine the aggregate amount.

Mr. SCOTT. And does Merck get what you allocated to them? Suppose they say, "Wait a minute, we can sell more than that"?

Mr. RANNAZZISI. Well, every year a quota is made, so every year they have an opportunity to re-request additional quota amounts. And I believe in the system we've built in where, if a company does need additional amounts, we're able to grant that, in some cases.

Mr. SCOTT. And if they have a complaint, like they feel they weren't treated fairly, what remedy do they have?

Mr. RANNAZZISI. They would again apply to DEA, and it would go through our process of reconsideration.

Mr. SCOTT. And if DEA is obnoxious, what remedy do they have?

Mr. RANNAZZISI. I believe——

Mr. SCOTT. I mean, suppose——

Mr. RANNAZZISI. I believe DEA is fairly——

Mr. SCOTT. No, suppose you've got two competing drug companies and you've allocated more to one than the other. I mean, can you go to court?

Mr. RANNAZZISI. It goes through the regulatory process. And there's a notice and comment period, and they can request a hearing.

Mr. SCOTT. And so when the DEA says, "Merck, no, you can't get any more cold medicine," that's it?

Mr. RANNAZZISI. Well, again, it goes through——

Mr. SCOTT. No remedy. Is there a remedy?

Mr. RANNAZZISI. Yes, I believe there is a remedy. I believe that's through the regulatory process, administrative process.

Mr. SCOTT. What about a lawsuit?

Mr. RANNAZZISI. I'm sure that—everybody, I think, has that opportunity to file a lawsuit, sir.

Mr. GOHMERT. The gentleman's time has expired.

I did want to ask questions. I got in this afternoon. My district has been hit by Hurricane Rita, and we were already holding quite a few folks from Hurricane Katrina. But I did want to ask, I mean, Texas has been restricting the numbers of pseudoephedrine that an individual could get for some time now. And I wondered if there was any empirical data that had been gathered from States that had been restricting the purchases of pseudoephedrine for a while.

Mr. RANNAZZISI. Well, the only full-year data set we have is from Oklahoma. And that was described in the interim report for the National Synthetic Drugs Action Plan Strategy. Oklahoma had approximately a 52 percent reduction, based upon their restrictions, which was a straight Schedule V restriction.

It was kind of like a hybrid Schedule V, because in Oklahoma you actually—there were three products—liquids, gel caps, and liquid gel caps—that aren't affected by that law, so they could be sold in the retail markets. Other than that, in Oklahoma Schedule V, they're sold in pharmacies only.

Now, there's other States, such as Oregon who went through the pharmacy board to create a regulation to make it similar to Schedule V. But if I'm not mistaken, the combination products—the single-entity products were Schedule V; the combination products were not—were kept in pharmacies only. The combination products were sold outside of the pharmacies. And I believe that was changed later on.

In Iowa, it's all Schedule V. Even if you have a trace amount of pseudoephedrine in the product, it's a Schedule V product.

So as you see, all the States are operating differently. Now, Oregon has shown a 42 percent reduction in the first 4 months of enactment, and that was in the interim——

Mr. GOHMERT. When you say 52 percent in Oklahoma and 42 percent in Oregon, reduction, in such a short turnaround, what is it? Fifty-two percent reduction in what?

Mr. RANNAZZISI. In lab seizures, clan lab seizures, a 52-percent reduction in clandestine lab seizures.

Mr. SOUDER. Mr. Chairman? Mr. Chairman?

Mr. GOHMERT. Yes, sir.

Mr. SOUDER. When we first held a hearing, I had the Oklahoma program come forth when it was brand new. I was enthusiastic

about this program. The fact is, Kansas doesn't have such a program. They have Meth Watch, and they also dropped. Indiana just did one that put it behind the counter, but not Schedule V, and guess what? Meth labs have dropped before the law was implemented.

The fact is that if you tackle this issue, and if you have a combined effort in the community—through law enforcement, through drug treatment, through prevention programs, through TV and newspaper awareness—it's a drug that's so bad that you can turn it around.

But over-reaction, which I believe is happening in some—Mr. Scott put it into the record. The Oregonian is reporting that they've had a rise now in meth in Oklahoma; only it's first coming in with the superlab stuff.

But the second thing is, we all know the biggest problem in drug trafficking is Internet. At least when it's going into a local pharmacy, you can kind of see where it's coming up. You can have the law enforcement come in, check it, figure out why a pharmacy is doing it. If these people start ordering on the Internet—and most of them will say they got the recipe on the Internet—if they start ordering from Mexico and Canada, we'll never find them. We won't have any control.

So what looks like a quick, short-term, 12- to 24-month solution, I would argue, is causing greater problems down the road. And I came through as an enthusiast for this initially. Maybe that's where we'll have to go if the epidemic gets too bad. But it's too quick of a political reaction to a complex, difficult, multi-level problem.

Mr. GOHMERT. I'd agree with you, except I do believe it is an epidemic. As a district judge in Texas, I was constantly sentencing people who were cooking or selling the results of the cooks. And of course, when it was a hot cook, well, that was a little easier to spot, because of the smell, and then when it went to the cold cook—of course, you could also find people after the explosions sometimes, in the hot cook. But the cold cook made it harder to catch them.

But for someone who is already on the record—because I've had to give my driver's license and everything else, just to get the Sudafed so I don't snore at night when I take the Sudafed and it opens up my sinuses—it's a real hassle to somebody that's law-abiding, plays by the rules. But I know those people that want it, they don't come in and turn their driver's license in like I did, and have all that stuff written down.

So I wasn't sure, from the law enforcement I've worked with and was a judge for so many years and dealt with it, that making honest, law-abiding people like me go in and have to be restricted in what we can get, and also now have to give in your driver's license, that it really made that much difference to people that were determined to be criminal.

It is an epidemic. It does need additional enforcement. Of course, some of the testimony I heard, if your neighbor is mowing his lawn at 3 a.m., he's a suspect, even if you don't smell the cook or whatever. [Laughter.]

That came up in one trial I was trying. If your neighbor is mowing at three, you may want to let law enforcement know.

But anyway, I just hate to rush head-long into anything, if it may sound like a good quick fix, when overall it may not actually be what fixes the problem, to a multi-faceted problem.

Now, my time has expired, but if you'd care to address, any one of you?

Mr. RANNAZZISI. Well, I just want to say that if you look at the States and what they've done, the States have tailored their legislation to their needs, what they feel their law enforcement needs. And it's all over the board.

We have some States that follow Federal legislation. We have some States, like Oklahoma and Iowa, that have gone to the extreme end. It's just a balance. We have to balance law enforcement needs with the legitimate consumer needs.

I didn't say one thing, though. If I'm not mistaken, Kansas was one of the States mentioned that was Meth Watch. I believe they went to a Schedule V, as well.

Mr. SCOTT. If I could ask one other question?

Mr. GOHMERT. The Chair yields to the gentleman from Virginia.

Mr. SCOTT. Could you tell me how this bill would affect convenience stores and drug stores?

Mr. SOUDER. What roughly happens is, in Indiana, after it was originally proposed as a Schedule V—in a Schedule V, it's got to be in a pharmacy. And in small towns, the grocery stores don't have pharmacies. In fact, they're lucky if they have a grocery store or a pharmacy any more, because it can't make money. In Indiana, just going behind the counter, which means you have more and more behind the counter—you have lottery tickets, you have cigarettes, you have everything else—that they've restricted—the practical implementation in the last 30 days has been they've gone from 120 alternative cold medicines down to 20. They can't put them all behind the counter.

Furthermore, as it starts to ripple through, when you realize it's only—even in a State like Oklahoma, it's not in the big cities. And in States like Indiana, it's not in the mid-sized cities. So you're restricting everybody in the cities from their ability to get cold medicine because you have an epidemic outside. But if you don't, they merely go to the adjacent State. But if we restrict it at the States, they're going to go to Canada and Mexico and the Internet.

The problem is the reason—with the Meth Caucus tomorrow, we're having a roundtable summit. And my frustration with this Administration is it takes every angle. It takes a law enforcement angle. I'm proud of this bill, and I believe it's a compromise. But we're also having ADMHA there tomorrow, we're having NIDA there tomorrow, we need—the National Institute for Drug Abuse, the Alcohol and Mental Health and Drug Substance, ADMHA. We need to have them working on treatment programs.

We need to have the Safe and Drug Free School Program looking at how to get the kids themselves involved in this. We need to have our community programs talking about a community effort. We need to be looking at every agency and how, when this hits, to get ahead of the curve.

This is one we've seen march west to east, Hawaii to California, going to the Midwest, now in upstate Pennsylvania, in eastern North Carolina. It's coming. It's coming inside out. It hit Dayton for the first time last week. And so we need to get ahead of this comprehensively.

Mr. SCOTT. My question was what effect the bill would have on drug stores and convenience stores.

Mr. SOUDER. The bill has no—has minimal effect. It restricts the, basically, 48-count; gets rid of the blister packs; gets it into a manageable form; starts to track the wholesale spot market.

As Mr. Rannazzisi said, you look at this, and you're trying to get the places where there are bulges in the market addressed. We're trying to get the big amounts of pseudoephedrine coming into the United States.

Mr. SCOTT. Well, I mean, you've testified that you're trying—is this thing targeted? I mean, because it sounds like the bill would apply where there's no problem and it would create the administrative hassles whether there's a problem in the area or not. Is that true?

Mr. SOUDER. What started this discussion was Mr. Coble's question to me about Schedule V with my bill. This bill is silent.

Mr. SCOTT. Well, my question—I don't know what Mr. Coble's question was—was if you're running a convenience store or a drug store or a grocery store, what difference would the bill make?

Mr. SOUDER. Minimal. That's quantity sales.

Mr. SCOTT. Quantity?

Mr. SOUDER. For the individual retailer, all it does is reflect quantity sales at that store. He's restricted if somebody comes in with a big blister pack, wants more than 48 at a time, he's restricted. But it's not behind the counter; it's not at a pharmacy. We're going at the wholesale national level.

There is another bill moving that Senators Talent and Feinstein have done in the Senate, that Congressman Blunt has in the House, that could be married to this. And I was expressing my opinions and concerns about that bill. This bill is de minimis impact on an individual retailer, and de minimis impact on people in Virginia and other parts.

Mr. SCOTT. Thank you, Mr. Chairman. And Mr. Chairman, I'd like a letter, testimony from the American Council on Regulatory Compliance, in reference to the legislation, and one from—and the other letter that I've cited from, signed by 92 professionals, suggesting that we need to focus on prevention.

Mr. GOHMERT. If there is no objection.

[No response.]

Mr. GOHMERT. I don't hear any down at either end. Okay. Well, without objection, then, those will be entered into the record.

[The information referred to can be found in the Appendix.]

Mr. SCOTT. Thank you.

Mr. GOHMERT. Anything else?

Mr. SOUDER. Mr. Chairman?

Mr. GOHMERT. Yes.

Mr. SOUDER. May I clarify one other thing from earlier? That we have a safety valve in this matter of sentencing. For people who aren't central to drug trafficking, it allows a sentence beneath the

mandatory minimum. You can't be charged as a kingpin if you aren't the leader of the organization. That's different than conspiracy. So kingpin is statured slightly different than conspiracy. It also allows the sentence to be negotiated if you turn in the higher-level person.

Mr. GOHMERT. All right. And by the way, that 3 a.m. mowing, it actually came out in a capital murder case, because the whole ring was involved, and one of them they were afraid was a snitch, and she was killed and stuffed in a 55-gallon drum. But anyway, unpleasant stuff we're dealing with. And it is an epidemic, and we appreciate your attention to that.

I do thank the witnesses for their testimony. This Committee thanks you—or this Subcommittee. And we appreciate all you're trying to do to help with the epidemic and the problem.

And in order to ensure a full record and adequate consideration of this important issue, the record will be left open for additional submissions for 7 days. Also, any written questions that a Member wants to submit should be submitted within the same 7-day period.

This concludes the legislative hearing of H.R.3389 [sic], the "Methamphetamine Epidemic Elimination Act." I thank you for your cooperation. This Subcommittee stands adjourned.

[Whereupon, at 5:31 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE ROBERT C. SCOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING MEMBER, SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

Thank you, Mr. Chairman. I am pleased to join you in convening this hearing on the "Methamphetamine Epidemic Elimination Act." Unfortunately, I am not able to join you in supporting the bill in its current form.

In the last 15 to 20 years, methamphetamine (Meth) abuse has grown to what some now refer to as epidemic proportions in parts of this country. We've been making efforts in the Congress for years to address the meth problem. The Subcommittee on Crime held 6 (six) field hearings on methamphetamine production, trafficking, and use in 1999, in Arkansas, California, New Mexico, and Kansas. Testimony was received from numerous witnesses, including former methamphetamine addicts, family members of the victims of methamphetamine related violence, law enforcement professionals, and prevention and addiction treatment professionals. Despite what we heard about the need for treatment and family support to get people out of meth's grip and back on track, the basic approach of the Congress has been to increase the number and severity of mandatory minimum sentences. Yet, the fact is that this approach clearly has not worked to stem the tide of meth and the fact that there is no evidence to suggest it ever will.

The evidence shows that treatment does work to stem meth addiction and abuse. Recently, in an open letter to the news media and policy makers, 92 researchers and treatment professionals stated that:

"Claims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and reincarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests the need to improve and expand treatment offered to methamphetamine users."

Drug Courts have proven especially successful in the case of methamphetamine treatment as an alterative to the "get tougher" approach. The Orange County, California, Superior Court Drug Court Program is an example of a program that has effectively addressed the methamphetamine problem. This court requires a minimum of an 18-month treatment program in which the graduate must be drug free for 180 days, have a stable living arrangement, and be employed or enrolled in a vocational or academic program. This Drug Court has a 72 percent retention rate, with 80 percent of the graduates not being rearrested for drugs and 74 percent with no arrest for anything.

Nonetheless, time and again, Congress has responded to this serious problem primarily with more and harsher mandatory minimums. In the Anti-Drug Abuse Act of 1988, Congress established a 5 year minimum for 10 grams of pure meth or 100 grams of meth mixture and a 10 year minimum for 100 grams of pure meth or 1 kilogram of meth mixture. In the 1990 Crime Control Act, Congress heightened sentencing for "Ice" a particular form of Meth. Then again in 1996, Congress responded to the still growing problem with even tougher mandatory minimums, by cutting in half the quantities of the pure controlled substance and mixture that would trigger the respective five and ten year mandatory minimums.

In the meantime, as the epidemic has grown exponentially despite these ever-increasing punitive approaches by the Congress, states have taken a similar approach, enacting harsher and harsher penalties and putting more and more emphasis on law enforcement. Yet, they have had no more success than Congress with this approach. A recent series of articles in The Oregonian newspaper reflected the frustrating results of this approach in Oklahoma, and ask unanimous consent to place

this article in the record. The article pointed out that while Oklahoma had great success in slashing the number of home meth labs through vigorous law enforcement, it failed to curb meth use. They found that in place of the local labs, a massive influx of meth made by Mexican "superlabs," where tons of pseudoephedrine can be easily obtained, had come into their locale, and that it was cheaper and better quality than the locally made stuff.

Despite the clear evidence that increasing penalties does not stem the spread or impact of meth, and despite the evidence that treatment does significantly decrease the problem, the response in this bill, yet again, is to increase mandatory minimum sentencing, even more. This bill would further lower the threshold amount of meth that triggers harsh mandatory minimum sentences. The major problem with this approach is that it will actually make meth more available. This is because lowering the quantity threshold for triggering mandatory minimums will cause federal prosecutors to concentrate even more on low-level offenders that are now being left to the states to prosecute. This will simply mean that we will be sentencing the same low level offenders to longer sentences, including those who are tied in through conspiracy and attempt laws which punish bit players the same as kingpins. This is what we have seen with the so-called crack epidemic, where we are seeing that over ⅔ of those sentenced for crack offenses are low levl offenders, generally addicts dealing to supply their habit. And now, her we go, in the words of Yogi Berra, with "de ja vue all over again."

So, Mr. Chairman, I look for word to the testimony of our witnesses with the hope that they will enlighten us on proven ways to stem this problem, rather than simply doing what we always do—put more low level addicts in prison longer, while the problem rages on. Thank you.

PREPARED STATEMENT OF FREDA S. BAKER, DEPUTY DIRECTOR, FAMILY AND CHILDREN'S SERVICES, ALABAMA STATE DEPARTMENT OF HUMAN RESOURCES

BOB RILEY
Governor

State of Alabama
Department of Human Resources

Page B. Walley, Ph.D.
Commissioner

Prepared Remarks of

Freida S. Baker, MSW
Deputy Director
Family and Children's Services
Alabama State Department of Human Resources

"Crystal Methamphetamine: The Impact on Children and Families in the Public Child Welfare System"

Before the House Government Reform Committee
Subcommittee on
Criminal Justice, Drug Policy, and Human Resources

US House of Representatives

26 July, 2005

An Affirmative Action/Equal Opportunity Employer

Good Afternoon. Thank you so much for the opportunity to speak with you about the impact of crystal meth on children and families in Alabama. I have been a social worker for nearly 24 years, and have worked with families who struggle with a myriad of issues. The crystal meth epidemic is as dangerous and challenging as any we have faced.

System Challenges

Without question, Crystal Methamphetamine poses a significant threat to vulnerable citizens in Alabama. The Alabama Department of Human Resources has several challenges with meth-related issues at the state level. First, we must ensure the safety of children and provide effective services to individuals affected by the drug. Second, we must prepare our workers through both education and direction. And third, we must craft policy and procedures so that consistent methods and safeguards are in place in each of the state's 67 counties. There are important implications to the agencies that serve these children and their families in that, unlike other abuse or neglect scenarios, the home environment not only poses an immediate health threat to the children, but to any individual charged with providing services in the home as well.

Alabama's child welfare training curriculum has a newly expanded focus on substance abuse. But now, in addition to clinical training around the dynamics of substance abusing families, workers must also be taught very specific meth-related investigative skills and cautions. For instance, workers are taught not to open any containers or smell, touch or taste anything from the residence, as the chemicals associated with cooking Meth are volatile and potentially toxic. Select training for social work staff now often mirrors law enforcement in terms of function and role with meth. Workers are now, for example, routinely taught to look around outside the residence for suspicious items used in making or using Meth such as vents or pipes sticking up from the ground, or "Booby trap" wires and surveillance cameras that appear to be there for no intended purpose.

Even with Alabama's caseload standards, we find that an already strained child welfare workforce of young, inexperienced staff is further burdened with the complex dynamics of crystal meth. We find that workers leave the agency because of personal risks, the nature of these cases and the challenges of working with these families. Crystal meth has further complicated this multifaceted issue in public child welfare.

Children in Crisis

The number of children in the custody of Alabama's Department of Human Resources has increased over the past three years. In 2001, there were approximately 5400 children in foster care at year's end. In 2004, that number had risen to 6346. That number continues to rise. Reports of child abuse or neglect related to crystal meth have risen dramatically. These increases reflect our systemic response to changing needs and issues, as the complexity of substance-abusing families presents a national challenge, particularly in the area of crystal-methamphetamine.

Removal of children from their families is traumatic, and the added complications of meth use compound this trauma. If children are removed from active meth homes/labs, workers are instructed to not take any of the children's clothing or belongings from the home as they may be contaminated. Familiar clothing, toys, blankets are often helpful for children in this distressing situation, yet meth prevents even those small gestures for them. If there is obvious contamination of the clothes a child is wearing, clothing is to be discarded and left at the scene, then the child must shower as soon as possible. The child's personal things are left at the scene to minimize contamination of other areas or people.

In 2001, only 3.9% of Alabama admissions to foster care were due to substance abuse. Last year in Alabama, nearly 20% of admissions into care were a result of family substance abuse. I wish to share highlights from eight of Alabama's 67 counties. In particular, the Northeast corner of the state has had a significant increase in meth-related issues. For purposes of brevity, the following acronyms and abbreviations have been used:

CPS –	Child Protective Services
CAN-	Child Abuse and Neglect Report
Meth –	Crystal Methamphetamine
DHR –	Department of Human Resources

County Struggles

Calhoun

June 2004, the agency dealt with 21 cases of children removed from their homes because of meth use by parents. In June 2005, the number more than tripled, climbing to 71.

Jan-April 2005, average 10-12 children entering care each month.

May 2005, 25 children entered care.

As of 6-15-05, 34 children had entered care by the halfway point of the month.

"The problem is more severe in the northeast part of the state", local Director John James said. "This area of the state has just been hammered," he said. The upsurge in the use of methamphetamine has made our caseload explode," he said.

Cherokee

Of the 33 children in care in March 05, eight (25%) entered the system due to meth

Cleburne

March 2002, 25 children in care.

March 2005, 53 children. (40% of those entries due to meth.)

Cleburne County DHR Director Marsha Busby described meth, saying *"Across the state, it's one of the main issues that we're facing,".*

Cullman

143 children in foster care as of March 2004. Seven of these or 4.8% were meth-related.
March 2005 170 children in care, 22 (nearly 13%) of whom were meth-related.

DeKalb
64% of current children entered care due to meth use by one or more parents.
55% ongoing cps cases are related to meth production or use in the home.

Geneva
Calendar year 2004 one of the top three counties in the state in Meth lab arrests
March 2004, 10 children entered foster care due to Meth.
March 2005, Geneva had 19 children who were in care due to Meth use.

Jackson*
March 2004, 88 children in foster care, (40.2% due to crystal meth use by parents/caretaker.)
March 2005, 130 children in care, (57.5% there due to crystal meth use by parents/caretaker.)

**At one "bust", social workers picked up seven children from three different families.*

Marshall
An estimated 80-85 % of current cps reports received are meth related
In July 1998, there were76 open CPS cases
Currently, they have 354 (the third highest in the state)
In July 1998 there were 51 foster care cases
The county currently has 171. Of those cases, 75 (44%) are meth related.

More detailed information about Marshall County mirrors what other counties report. The county is near both the Tennessee and Georgia borders. According to local administrators, the county has been "dealing with the crystal meth issue" for several years, with an increase in all cases (CANS, CPS, and Foster Care) coming from the problem. As far back as 1998, that county was averaging 40-45 CANs during a month. That number increased in January 2001, when they began seeing numbers like 63 (Jan. 2001), 75 (May2001), 92 (Aug. 2001) and to a peak of 109 in March 2003. An estimated 80-85 % of these current reports received are meth related, with effects like inadequate supervision, poor hygiene, domestic violence, odd mental health-like symptoms (severe paranoia, hallucinations, with bi-polar/schizophrenic tendencies) and access to dangerous and lifethreatening objects (poisonous gases, drug paraphernalia, large numbers of illegal firearms, etc.).

There were 76 open CPS cases in Marshall County in July 1998. Currently, they have 354 (the third highest in the state). These numbers have increased due in large part to the number of crystal meth cases.

Foster care seems to be following the same trend as the county has found more and more cases where there are no relatives able to care for the children in meth cases because the entire family is abusing the substance. There were 51 foster care cases in

July of 1998 and Marshall currently has 171. Of those cases, 75 (44%) are meth related.

Kathleen Rice, Marshall County Supervisor, had these comments. "Issues that we are facing right now are dealing with parents and relatives endangering their children by using, selling, or manufacturing meth, and the children affected by this. We are, however, beginning to see a whole new dimension of the problem, in that we are now seeing younger children and youths using and getting in trouble with the law. It is also beginning to trickle into adult services in that we are seeing adult children stealing from elderly parents to feed their habit. Because of these issues affecting such a wide range of individuals, Marshall County recently received a $500,000 UPS community grant to improve our community approach to dealing with the issue."

Statewide Information

Even in counties where numbers of children in care have remained fairly stable, they cite crystal meth as being a much more frequent reason for removal than 18 to 24 months ago. Statewide efforts are underway to explore all treatment scenarios, to standardize protocol for services to these families, and to train social workers to assess these families appropriately. The problem calls for coordination with law enforcement agencies, safety instructions for workers and, should the need arise, decontamination instructions for clients and workers.

If called with law enforcement to a home where children have been exposed to a Meth Lab, workers are trained to allow officers to decontaminate children first if they have the equipment necessary. They learn about obvious signs of contamination such as visible residue, stains, powders, liquids, or solid on skin, clothes or shoes. Detectable odors such as ammonia, urine like, garlic like, solvent like, ether, gas, lacquer thinner, camp stove fuel, sulfur like or skunk like smells are usually present as well. Children in these settings often display physical distress symptoms including respiratory difficulties, chronic cough, skin rashes, redness rashes, blisters, and white patches.

Troy King, Alabama's Attorney General, has designated a Task Force to address issues caused by crystal-meth. DHR staff are members of the Task Force. The Alabama Legislature recently passed legislation regulating items that can be purchased to make crystal meth. The Governor's Office has a Faith-Based Substance Abuse Treatment Task Force. Meanwhile, the system response to issues of imminent danger in these families is to assess safety quickly and plan accordingly.

Faith-Based Strategies

The Treatment Community in Alabama has recognized the powerful addiction crystal meth imposes. Jon Schafer, Executive Director of Pathfinder, a 12-step, spiritually based in-house treatment program in Huntsville, reported that 40% of the entries over the last year had been due to crystal meth. He reports that visitation with their children is often a motivating factor in parents becoming sober. He explained that his program is a minimum 90 day in-house, with a maximum of 15 months stay. Through help from family, community, and spiritual support, one woman recently regained custody of her child who had been in foster care for 15 months while she received treatment. That

woman has now been clean and sober for six months and is a sponsor to another woman at Pathfinder.

The church community in Mobile has embraced the clientele at The Shoulder, a private, Christian-based in-patient treatment facility for substance abuse. Employees at this facility, when faced with funding shortages three years ago, voted to take a decrease in pay in order to keep serving the community. "Pearl", a long-time employee in the program component of The Shoulder, said that clients are linked to their own families and others through the generosity of church members who transport them, host lunches for them, or bring their children from foster care for visits on Wednesday nights or Sunday afternoons. One striking component of this facility is that 95% of their staff have successfully completed substance abuse treatment, and know the physical, emotional, and spiritual toll this takes on each client and each family member.

Rev. Elizabeth O'Neill of Immanuel Presbyterian Church in Montgomery relates that awareness of addiction as a disease is crucial to the faith community. The Presbyterian Church worldwide observes Addiction Awareness Sunday once a year. Educational material and liturgical opportunities are emphasized on that Sunday. Rev. O'Neill believes that a greater understanding of addiction locally and nationwide can be accomplished through faith-based work.
A young local AA group recently talked to parents of church youth at Immanuel, and members found it powerful to hear from peers of their own children's age group.

Traditional resources and new, creative strategies must be employed across all human service agencies if we are to prevent and treat the abuse of crystal meth and all substances. America's children and families deserve our best efforts, and your ongoing commitment to the safety, permanency and well being of our children is critical.
Thank you for your time and attention. I am grateful for the opportunity to share with you how crystal methamphetamine is affecting the lives of Alabamians.

Freida S. Baker, MSW, is the Deputy Director for Child and Family Services for the State Department of Human Resources in Montgomery, Alabama. She has a 24-year career in social work, and has been instrumental in the ongoing implementation of Alabama's 1992 landmark R.C. Consent Decree, a model for at least 20 other states' reforms. She is a certified federal reviewer. She has reviewed cases and has trained social workers, judiciary, educators, and other partners in Alabama and across the nation, including North Carolina, Maine, Colorado, Georgia, Utah, Florida, and Iowa.

PREPARED STATEMENT OF PREPARED STATEMENT OF LAURA J. BIRKMEYER, CHAIR, NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN, AND EXECUTIVE ASSISTANT TO U.S. ATTORNEY, SOUTHERN DISTRICT OF CALIFORNIA, UNITED STATES DEPARTMENT OF JUSTICE

Department of Justice

STATEMENT

OF

LAURA J. BIRKMEYER
CHAIR, NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN
DIRECTOR, NATIONAL METHAMPHETAMINE CHEMICALS INITIATIVE
EXECUTIVE ASSISTANT U.S. ATTORNEY, SOUTHERN DISTRICT OF CALIFORNIA
UNITED STATES DEPARTMENT OF JUSTICE

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES
OF THE COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

"FIGHTING METH IN AMERICA'S HEARTLAND: ASSESSING THE IMPACT ON LOCAL LAW ENFORCEMENT AND CHILD WELFARE AGENCIES"

PRESENTED ON

JULY 26, 2005

Chairman Souder, Ranking Member Cummings, and distinguished members of the Subcommittee, it is an honor to appear before you today to discuss the plight of drug endangered children in our nation and what we can all do to assist these victims whose lives are devastated by drug use, trafficking, and manufacturing on the part of their parents or "caregivers." I am currently the Executive Assistant U.S. Attorney for the Southern District of California and have prosecuted methamphetamine and precursor chemicals cases for a large number of my 18 years there. But I speak to you today as the Chair of the National Alliance for Drug Endangered Children ("The Alliance"). The Alliance was formed in October 2003 and is a growing organization which promotes public awareness for the problems faced by drug endangered children. The Alliance encourages communities to intervene on behalf of children, and to establish Drug Endangered Children (DEC) multi-disciplinary programs to rescue, defend, shelter and support them. The Alliance sustains a nationwide network of professionals serving drug endangered children by providing referrals to experts, updated research on topics concerning drug endangered children and best practice information.

Since 1999, I have also served as the Director of the National Methamphetamine Chemicals Initiative (NMCI) which was the first federal, state and local law enforcement coalition to encourage on a nationwide basis the participation in DEC teams as a "best practice" for all levels of law enforcement. The NMCI is comprised of hundreds of federal state and local law enforcement, prosecutors, forensic chemists and intelligence analysts. Our goal is to comprehensively attack and ultimately reduce methamphetamine production by denying availability of essential chemicals, precursors and equipment to methamphetamine manufacturers. The NMCI does so by encouraging and facilitating investigation and prosecution of chemical suppliers. The NMCI provides the most current methamphetamine production and chemical trend intelligence to all levels of law enforcement and works to heighten the chemical industry's awareness of the problem of chemical diversion. The NMCI also provides information and training to law enforcement and prosecutors on effective best practices relating to chemicals enforcement and prosecution.

The Plight of Drug Endangered Children

This committee has heard a great deal of testimony about the scope of methamphetamine use and manufacturing in the United States. Drug endangered children are at risk in homes where methamphetamine is manufactured and homes where parents live a "methamphetamine lifestyle." That lifestyle may spiral into dysfunction so great that children emerge as adults only to repeat the generational abuse that they grew up knowing so intimately.

If this were a different venue, I would present to you the many pictures and video clips we have collected of the living conditions found in the "homes" of children where law enforcement officers have uncovered methamphetamine use or manufacturing. Words do not adequately describe the danger of these environments. They are homes where the sheets, if there are any, are never washed. They are homes where children's bedrooms are used to store drugs. They are homes where toxic waste from methamphetamine manufacturing is routinely poured down the bathtub drain or down the kitchen sink. They are homes where the plumbing doesn't work and where the refrigerator is empty or filled with moldy, rotten food. Commonly, the refrigerator, the only reliable shelving in the residence, is used to store chemicals or finished drug products which contaminate

any food stored there. The sinks overflow with dishes, the carpets are stained with the chemical waste from methamphetamine cooks, and 2- liter soda bottles are used to store toxic and caustic chemicals that, when ingested by a child, burn lips and scar the esophagus.

They are also homes where the doorbell rings all day and all night during binge cycles and where a constant stream of strangers, ex-felons, registered sex offenders and poly-drug users come and go to buy and use methamphetamine. The air is filled with second hand smoke that is precipitating out on surfaces throughout the house. Routine urine toxicology screens frequently reveal low levels of methamphetamine in the children found in these environments – signaling a chronic exposure to the byproducts of their parent's methamphetamine lifestyle. The children are often "parentified," and are left to look out for themselves and younger siblings while their parents binge, sleep, and cope with their drug habit. There is, in short, unconscionable neglect in a population of children that is only recently emerging into public view as a public health problem.

All of these children, even those that emerge without serious bodily injury, suffer enormous psychological harm, degradation and lack of nurturing. They grow up in environments rife with domestic violence and where the risk of sexual abuse is far greater than normal environments. They grow up on their own: no one is reading to them at night, no one is making sure that they don't run into the street or fall out of a tree, no one is making sure that they see a pediatrician and that their immunizations are up to date, no one is taking them to the dentist, no one is cooking them nutritious meals. Their parents are poisoning their lives.

Methamphetamine affects the body and particularly the brain in a way that lingers long after ingestion occurs. Studies by NIDA Director Nora Volkow and others have just begun to show that methamphetamine alters brain chemistry for months and years after drug use ceases. The effects on the brain may potentially alter parental behavior and impair ability to parent. Parents in drug treatment may not "recover" in sufficient time to prove competent enough to be reunified with their children.

I cannot point to any study that accurately quantifies the number of children in America endangered by parental drug use or trafficking. Information from the Clandestine Lab Seizure System (CLSS) at the El Paso Intelligence Center, shows that 3,587 children were found in association with clandestine labs reported to EPIC in 2003 and 3,357 children were affected by clandestine labs in 2004. However, we know that these incidents are underreported and that the CLSS gathers only data relating to what law enforcement officers encounter at methamphetamine and other illicit drug labs. On the other side of the coin are the children living in the homes where drug use is fueled by meth manufacturing.

Many counties are now attempting to count the numbers of drug endangered children and to distinguish between children removed from meth labs as opposed to meth lifestyle homes. In San Diego, my home county, DEC teams have taken more than 400 children into protective custody in the past 12 months. Significantly, more than 95 percent of these children came from environments where there was methamphetamine use and trafficking but where manufacturing was not occurring. Approximately one in ten of these children tested positive for methamphetamine and of those the

children ages 0-6 were twice as likely to test positive for methamphetamine than children aged 7-14. An overwhelming majority of these children were flagged for follow-up after being administered a standard child development examination. The same trend is emerging from Butte County, California -- the birthplace of the DEC concept -- where meth labs account for only 5% of the children taken into protective custody. From 1999-2004, DEC teams have responded to over 900 children in Butte County. However, medical personnel report that our national meth lab statistics and individual county statistics do not begin to capture the number of children not identified in police raids or during child welfare visits who have died as a result of accidents or abuse in drug homes, or who have increased health risks and hazards and developmental delays resulting from exposure to drugs in the home. I believe, and represent to you, that the number of children at risk is large.

A Means for Assisting Drug Endangered Children: DEC Teams and Programs

There is a paradigm-shift taking place at the state and local level; confronting the plight of drug endangered children requires multi-jurisdictional perspective and leadership to form DEC Teams. DEC Teams made up of law enforcement, child welfare workers, medical professionals, and prosecutors are the brainchild of Susan Webber-Brown, a District Attorney's Investigator with Butte County. The DEC Team concept was implemented in 1997 in a pilot project in California. The participants are trained to view children found at narcotics crime scenes as crime victims. Typically, when law enforcement executes a warrant, or begins an investigation of a drug crime scene, whether it be manufacturing, trafficking, or personal use, and when a child is found at the scene, a child welfare professional responds to the scene to work in concert with law enforcement. The child welfare professional reviews the crime scene with law enforcement and determines if the child needs to be taken into protective custody. Children deemed at risk benefit from a medical protocol urging a timely medical examination, a urine toxicology screen, a developmental evaluation and other appropriate care.

Drug endangered children are evaluated for placement in a safe environment either with a non-offending parent, family member, or in the foster care system. A prosecutor will determine if criminal child endangerment charges are appropriate and may seek to secure court orders to delay reunification with parents until they are demonstrably drug-free and able to care for their children and may, in some circumstances, petition to terminate parental rights.

While the concept is straightforward and logical, implementation requires leadership and perseverance. Narcotics officers are frequently not trained to prepare child abuse reports and child abuse detectives who are skilled in searching for discreet evidence of child neglect and abuse are rarely called to narcotic crime scenes. In some jurisdictions, the relationships between child welfare services and law enforcement are strained. DEC teams cannot function without a close relationship with the medical community and with pediatricians and emergency room doctors that understand the medical needs of this population. Often, lacking the appropriate reports and medical records, prosecutors overlook the need to file child endangerment charges or lack the training to put together a successful case.

Although the basic structure of a DEC team envisioned by Susan Webber Brown remains the same, the psychologists, child welfare, and drug treatment professionals who participate in the Alliance are teaching us that children need more. We have a rare opportunity: a window of safety is opening, however briefly, in each of the lives of the children that are rescued by the DEC teams. They are victims of crime that suffer from a host of behavioral, emotional and cognitive problems caused by the methamphetamine culture in which they've been immersed. They need timely evaluation of their cognitive development. They may need to be followed long-term as some of the psychological manifestations of being raised in drug environments and exposure to abuse may not surface until months after they are removed from such environments. We should recognize that we have a fleeting chance to break the cycle of abuse: we can aspire to nothing less than ensuring that they don't grow up to use drugs, to drop out of school, or to be arrested.

As recently reported in the New York Times on July 11, 2005, an increased number of children are being referred to foster care and shelters, primarily due to the rise in meth-addicted parents and meth labs. As those children enter foster care, they stress a system that searches for a way to enable the coordinated provision of services. And, as noted in the article, better preparation of the foster parents for the behavioral and medical issues attendant to children exposed to methamphetamine environments is needed.

Implementing DEC Programs in our Nation

States and counties have different resources and different structures and there is no one-size fits all model for implementing a DEC program in a community. In order to begin the process, communities and states need to be armed with information and knowledge. The National DEC Training Program, which is administered through the U.S. Department of Justice and the U.S. Attorney's Office in San Diego, commenced in early 2004. Following receipt of grant funds to hire a National DEC Training Coordinator and to implement the program and provide cost-free training to requesting states, we assembled teams of experts and worked with those experts to design a standardized curriculum. Training teams consisting of law enforcement officers, prosecutors, doctors and nurses, child welfare specialists and psychologists provide instruction on the environments in which children are found and the needed response by law enforcement, child welfare and medical and mental health personnel. Much of the instruction is directed toward the particular harms of methamphetamine since many of the requesting areas choose to develop DEC programs in response to methamphetamine crime waves. The training encourages team building and dialogue between agencies who may not have previously collaborated on children's behalves. Our program is designed to assist those in rural, suburban and urban areas. It also urges communities to recognize that children in homes where heroin, cocaine, marijuana, prescription and synthetic drugs of abuse abound also suffer from abuse and neglect which necessitates intervention and child protection.

National DEC instructors are experts in their various fields and affiliated with the Alliance. They donate their time or have their agencies' encouragement to participate. In 2004, the National DEC Training Program provided comprehensive two day programs for more than 2500 professionals from multiple disciplines in fifteen cities in twelve different states. In addition,

thousands more in the United States and abroad have received DEC awareness lectures from me, Ronald Mullins (our National DEC Training Coordinator), and other members of the Alliance at professional conferences, state methamphetamine summits, and other training events. This year, to date, the two day training has been provided in twelve cities in eight different states to more than 3000 professionals from multiple disciplines. Trainings are scheduled to occur in another seven states over the course of the next five months. We are in the process of designing a train-the-trainers program. As the participation in DEC programs becomes a standard practice for law enforcement, child welfare services, victim-witness units, and public health agencies in communities across the nation, training will become ever more critical.

An Evolving Response to the Problem

DEC programs are flourishing in states which have active statewide alliances or strong regional partnerships. Other states are working hard to implement DEC programs in drug saturated areas. As of last week, 25 states have DEC programs in regional areas or have statewide DEC Alliances dedicated to unifying individual counties' efforts to assist drug endangered children.

The Alliance has developed an inclusive network of professionals from many disciplines dedicated to increasing awareness of the problems faced by drug endangered children. We use every opportunity to speak to physicians, nurses and public health personnel, scientists, researchers, forensic chemists, prosecutors, drug court personnel, substance abuse treatment providers, law enforcement, social workers, community leaders and the public to let them know that these child victims are out there and in need of our help.

We know we need to design our care for these children based on reliable data and research which accurately identifies the harm to children found in drug homes. Dr. John Martyny of the National Jewish Medical and Research Center has conducted ground-breaking research, with the assistance of DEA chemists and law enforcement personnel in three different states, looking at the nature and extent of contamination created by methamphetamine labs during the "cooking" process. Copies of their studies are available on the web at www.nationaldec.org and www.njc.org. The Alliance currently facilitates a project involving Dr. Martny and other researchers who are designing a study to measure the effects and extent of contamination during long term exposure to meth lab sites and to evaluate the different methodologies for decontamination and cleanup of these lab sites.

In 2004, the Alliance formed a Medical and Scientific Research Working Group comprised of pediatricians, psychologists, mental health professionals, scientists, toxicologists, epidemiologists, forensic chemists and researchers. That group delineated the studies that needed to be done to determine the ways in which children are affected by methamphetamine environments and how to construct research projects which would isolate the specific health risks of methamphetamine. The group has also identified the behavioral issues that appear to present in methamphetamine endangered children and is encouraging further investigation of the treatment that developmentally delayed children would need. Most importantly, the working group produced a national protocol for the medical evaluation of children found in drug labs, which has been

adopted by and used in a number of states. (A copy of the protocol is available at www.nationaldec.org). The goal of this working group and the other working groups of the Alliance is to survey the experts and, based on their experience and training, provide guidance and assistance and share information with individual state alliances and community DEC programs so that they do not have to "reinvent the wheel."

This week, in San Diego, California, the Alliance brought together a working group of drug treatment experts to identify the most effective treatment programs for methamphetamine users, and to evaluate and recommend programs which address the treatment needs of families and in particular dependent children. They will also design an awareness program which will be used to notify drug treatment providers of the immediate and sometimes dangerous consequences for dependent children when parents or caregivers relapse.

The Alliance also hosts working groups for Child Welfare professionals and is forming a working group to address Victim-Witness issues. Out of these newly constructed groups we hope to develop plans for increased access to services to help with the long-term physical and psychological needs of drug endangered children.

In June, 2004, the Alliance held a very successful national Drug Endangered Children conference addressing the important medical, psychosocial, scientific, legal, social service and data collection topics concerning drug endangered children. This October, in Washington, D.C., the Alliance will host a second conference designed for the many disciplines involved in DEC programs as well as policy makers and community leaders. The conference will address current problems and challenges facing all disciplines in implementing and sustaining DEC programs and encourage the participation of treatment providers, drug courts and educators in DEC programs.

The Future

Although increasing the strain on already burdened child welfare systems, we know that rescuing children from drug environments is the "right thing to do." You can see it in the eyes of officers and sheriff's deputies who are as proud of the fact that they saved a child as they are with a large drug seizure and a significant arrest. You can see it in the actions of family members and neighbors who contact child protective services or the police because "it's not right" to expose children to drug environments. You can feel it in the urgency with which communities request assistance and training.

I wish to finish this statement with a note of hope. The psychologists and others who have worked with the Alliance and who have treated these children send a clear message. Children are resilient. If given the opportunity and a caring environment, they will thrive. The National Alliance has as one of its goals the hope that as we publicly address this national problem, children will not be tagged as "meth orphans" or "crank babies" as if they are irreversibly damaged. At the very core of every drug endangered children program is the fervent shared belief that by intervening in these children's lives we will break the cycle of drug abuse.

PUBLICATION ENTITLED "THE METH EPIDEMIC IN AMERICA, TWO SURVEYS OF U.S. COUNTIES: THE CRIMINAL EFFECT OF METH ON COMMUNITIES, THE IMPACT OF METH ON CHILDREN, SUBMITTED BY THE NATIONAL ASSOCIATINO OF COUNTIES (NACO)

The Meth Epidemic in America

Two Surveys of U.S. Counties:

The Criminal Effect of Meth on Communities
The Impact of Meth on Children

July 5, 2005

Angelo D. Kyle
NACo President

Bill Hansell
NACo President-Elect

NACO National Association of Counties
Counties Care for America

Executive Summary

The methamphetamine epidemic in the United States, which began in the West and is moving East, is having a devastating effect on our country. The increasingly widespread production, distribution and use of meth are now affecting urban, suburban and rural communities nationwide. County governments across America are on the front lines in responding to the methamphetamine crisis.

For counties, meth abuse causes legal, medical, environmental and social problems. County governments and their citizens must pay for investigating and closing meth labs, making arrests, holding lawbreakers in detention centers and then trying them, providing treatment for those addicted to the drug, and cleaning-up lab sites.

There are also many societal effects that must be considered. In an alarming number of meth arrests, there is a child living in the home. These children many times suffer from neglect and abuse.

Meth labs pose a significant danger in the community, as they contain highly flammable and explosive materials. Additionally, for each pound of methamphetamine produced, five to seven pounds of toxic waste remain, which is often introduced into the environment via streams, septic systems and surface water run-off.

The meth epidemic is a complex problem that is not easily solved. To better understand the extent of the problem, the National Association of Counties (NACo) recently conducted surveys of law enforcement and county child welfare officials in order to determine the impact of meth on these county services and their communities.

The surveys were conducted by Research, Inc. of Washington, D.C. Results from 500 counties from 45 states comprise the survey, "The Criminal Effect of Meth on Communities." The results of the survey, "The Impact of Meth on Children," are based on responses from 303 counties from all 13 states where child welfare activities are performed at the county level. Here is a summary of the survey results.

The Criminal Effect of Meth on Communities

- **Meth is a growing problem that is now national in scope.** Of the 500 responding law enforcement agencies, 87% report increases in meth related arrests starting three years ago.

- **Meth is the leading drug-related local law enforcement problem in the country.** Fifty-eight percent of counties in this survey said that methamphetamine was their largest drug problem. Meth was followed by cocaine (19%), marijuana (17%) or heroin (3%) as the number one drug problem.

- **Meth related arrests represent a high proportion of crimes requiring incarceration.** Fifty percent of the counties estimated that 1 in 5 of their current jail inmates were housed because of meth related crimes. The problem is even worse in the other half of the counties surveyed. Seventeen percent of the counties report that more than half of their populations are incarcerated because of meth related crimes.

- **Other crimes are increasing as a result of meth.** Seventy percent of the responding officials say that robberies or burglaries have increased because of meth use, while 62% report increases in domestic violence. In addition, simple assaults (53%) and identity thefts (27%) have also increased.

The Impact of Meth on Children

- **Meth is a major cause of child abuse and neglect:**
  - Forty percent of all the child welfare officials in the survey report increased out of home placements because of meth in the last year.
  - During the past five years, 71% of the responding counties in California reported an increase in out of home placements because of meth and 70% of Colorado counties reported an increase.
  - More than 69% of counties in Minnesota reported a growth in out of home placements because of meth during the last year, as did 54% of the responding counties in North Dakota.
- **Meth hurts children and families over the long-term.** County officials were asked if the particular nature of the meth user parent has increased the difficulty of family reunification and 59% said yes.

Survey 1

The Criminal Effect of Meth on Communities' Law Enforcement Agencies

In response to the rapid escalation of the methamphetamine epidemic, the National Association of Counties conducted a survey of 500 county law enforcement agencies in 45 states to determine the impact of this drug on their communities. In this telephone survey, conducted by Research, Inc., information about the impact of methamphetamine use on public safety programs and criminal activities was requested.

Crime and police activities have increased in response to meth growth. As the numbers of people who used meth grew and the numbers of people who became addicted to meth grew, police involvement also grew. Meth users were criminals who committed other crimes while under the influence of the drug and also to finance the purchase or manufacture of the drug. County law enforcement officials began to see a dramatic increase in the number of arrests that involved this drug.

Increases in Arrests involving Methamphetamines

In the recently conducted survey, county public safety officials were asked about the percentage increases in arrests related to methamphetamine for the following three time periods – during the last 5 years, during the last three years and during the last year. The results indicate continuing increases during the specific periods.

Increases during last five years

Of the 500 responding law enforcement agencies, 88% report increases in meth related arrests starting 5 years ago. Regionally, the areas reporting the greatest increases starting 5 years ago are the Upper Midwest, Southwest and the Northwest, each reporting a 93% increase. These areas are followed closely by the Lower Midwest with a 90% increase. The lowest reported increase in meth related arrests starting 5 years ago, was in the Northeast, which reported a 54% increase.

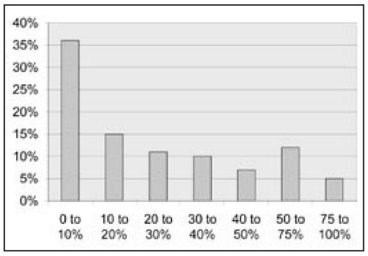
The states reporting the highest percentage increase in meth related arrests starting 5 years ago are Arizona, Arkansas, Florida, Indiana, Iowa, Louisiana, Minnesota, Mississippi, Nevada, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Washington and Wyoming, all reporting a 100% increase in the rate; Georgia reporting a 96% increase; Colorado and Missouri, both reporting a 95% increase; South Dakota and Kansas, both reporting a 94% increase and Idaho, California and Montana, all reporting a 90% increase.

Increases during last three years

Of the responding counties, 87% report increases in arrests involving meth starting 3 years ago. The Southwest leads the increases, reporting a 96% increase, followed by the Northwest with a 90% increase. Again, the Northeast is the lowest, reporting a 58% increase in meth related arrests during this time period.

The states reporting the highest percentage increase in meth related arrests during the last three years are Arizona, Arkansas, California, Florida, Indiana, Louisiana, Minnesota, Nevada, New Mexico, Ohio,, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Washington and Wyoming, all reporting a 100% increase; Iowa and Mississippi, both reporting an increase of 95%; South Dakota, reporting an increase of 94%; Georgia and Kentucky, both reporting an increase of 92%; Illinois and North Dakota, both reporting an increase of 91% and Idaho with an increase of 90%.

Figure 1: Percentage Increase in Meth Related Arrests in Last 5 Years



Increases during the last year

This data for the 500 respondents indicates that for most regions, the rate of increase in percentage of meth related arrests is slowing somewhat since only 67% reported continuing increases for this time period. The Southwest led the increases again with 76% reporting continuing increases in arrests, while the Northeast again reported the lowest, a constant 58% increase for the last year, the same as for the three year period.

Just as at the national level, the continuing rate of increases in the percentage of arrests related to meth state by state has slowed. The highest rate of continuing increase was reported in Arkansas and Utah, both reporting 100%; while Idaho reported a 90% increase; Wyoming reported an 89% increase and New Mexico reported 88%.

Total Methamphetamine Related Arrests

More than 51% of the 500 responding local law enforcement agencies report that up to 20% of arrests made in their counties during the last 5 years are methamphetamine related, while 17 % report that more than 50% are related. Twenty four counties report that between 75 and 100% of the arrests made in their counties during this period are meth related. *See figure 1.*

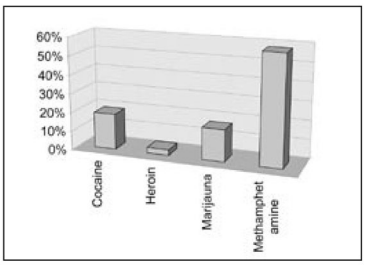
On the national level, the federal government still considers marijuana as the number one drug problem in America, but county law enforcement officials have a different perspective on this ranking. With the growth of this drug from the rural areas of the western and northwestern regions of this country and its slow but continuing spread to the east, local law enforcement officials see it as their number one drug problem.

What is the Primary Drug Problem in Your County?

Law enforcement officials in all 500 responding counties were asked, using drug related arrests in the last year, to select the drug that was the biggest problem in their county. Although some counties across the country still rated cocaine (19%), marijuana (17%) or heroin (3%) as their number one drug problem, 58% percent of counties in this survey said that methamphetamines were their largest drug problem. *See figure 2.*

Taking a look at the regional responses to this question, 76% of counties in the Southwest rate methamphetamine as their number one drug problem and 75% of counties in the Northwest say the same. Sixty seven percent of counties in the Upper Midwest rate meth as their number one drug problem. Conversely, only 4% of counties in the Northeast rate meth as number one, while 46% rate heroin as number one and 21% rate marijuana as number one. Since the Northeast is the nation's most urbanized area, this data supports the long held belief that methamphetamine use has for many years been seen as a rural phenomenon. This appears to be changing however, since 57% of the officials in the Lower Midwest ranked meth as its number one drug, and 26% of the officials in the Southeast did the same.

Figure 2: Primary Drug Problem



Methamphetamine Impact on Jails

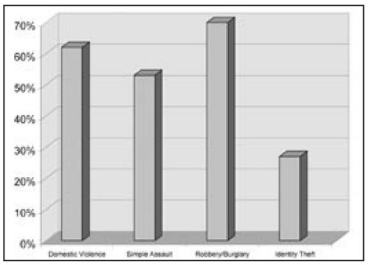
The growth of the use and addiction to methamphetamines has occurred so fast and to such a degree that many local governments are scrambling to catch up. Only 16% of the law enforcement officials report that their county either facilitates or sponsors a meth rehabilitation center or program, while 81% report that they do not. As a result, many abusers of this drug who have committed crimes are housed in local jails.

Officials were asked to estimate what percentage of their local jail inmates were there because of meth related crimes. Of those responding, 50% estimated that up to 20% of their current inmates were housed because of meth related crimes. In the smallest population groups, counties with populations below 50,000, 6% of the counties estimate that 75 to 100% of their inmates are housed because of meth related crimes. In the Upper Midwest, 7% report that 75 to 100% of the jail population are being held because of meth related crimes.

Crimes Increasing Because of Meth

Although the use of methamphetamines is itself a crime, there are several other crimes that have been increasing because of the prolific use of this drug. Seventy percent of the responding officials say that robberies or burglaries have increased because of meth use, while 62 percent report increases in domestic violence. In addition, simple assaults (53%) and identity thefts (27%) have also increased. *See figure 3.*

Figure 3: Increase in Crimes Because of Meth Use



Impact of Meth on Law Enforcement Activities

The increased presence of meth in many counties across the nation has increased the workload of 82% of the responding counties. In the Southwest, 93% of the counties report an increased workload while 88% of the counties in the Northwest report an increase. These increased law enforcement activities that have been attributed to the increased use of and addiction to methamphetamines are putting a heavy financial burden on local law enforcement activities. As a result, 52% of the responding counties say that they have to pay more overtime, while 13% have changed work assignments of police personnel to accommodate the increased need for police power. Eleven percent of counties say that they are assigning their officers to longer shifts to address this growing crisis.

As a means of waging a war against the methamphetamine epidemic, many counties are targeting the labs that are built to manufacture the drug. Many of the labs that remain in this country are small labs, and are often portable. Although toxic and dangerous to the environment, they have been flourishing in recent years. Sixty two percent of the county law enforcement officials report that lab seizures have increased in their counties in the last 3 years. In the Lower Midwest, 74% report increases in lab seizures, while 68% of counties in the Upper Midwest report increases. Even the Northeast, where very few county officials rank meth as the number one drug problem, reports a 42% increase in lab seizures during the last 3 years.

How are counties addressing this problem? First and foremost, most recognize that methamphetamine use is spreading. Local law enforcement officials also acknowledge that for every lab that they close down, 10 new ones are created. They also know that many of

the safeguards that have been put in place to reduce the ability of the "cooks" of these drugs to obtain the necessary materials that they need to manufacture this drug have sent the largest manufacturers into Mexico and Canada, which are now responsible for the exportation of large amounts of meth. In order to tackle this problem head on, 52% of counties have established interagency special task forces and 60 % are members of intergovernmental or regional task forces that have been created to battle this epidemic.

❖

Survey 2

The Impact of Meth on Children Out of Home Placement

There are many innocent victims of the increased use of methamphetamines in this country. To understand who they are, it is important to look at the drug's effects. Meth is favored by many drug users because it alters their moods. Since there are several ways that the drug can be taken, its effects will differ based on the method used. If smoked or taken by intravenous injection, there is an intense high that lasts for just a few minutes but has been compared to crack in its pleasure. Smoking or injecting will give the fastest high, sometimes in as little as 5 to 10 seconds. The high from snorting or eating the drug does not produce the intense rush that other methods do.

The drug, which stimulates the central nervous system, can create effects that can last for nearly an entire day. It modifies the behavior of the users, and after lengthy use it can actually change the way the brain functions. Meth has been known to cause heart failure, brain damage and stroke. It is also responsible for many psychological changes in the user. These psychological affects can cause anger, panic, paranoia, hallucinations, repetitive behavior, confusion, jerky or flailing movements, irritability, insomnia, aggression, incessant talking and convulsions. Many of these side effects can lead to violent aggressive acts and suicide.

Now add a child to this volatile mixture. Pregnancies of methamphetamine-addicted mothers can produce birth defects, low birth weight, attention deficit disorder, and other behavior disorders. In addition, the side effects of the drug that are affecting the parents create a greater risk of child abuse, shaken baby syndrome and neglect.

As law enforcement officials are clamping down on the manufacture and use of meth, they are finding a disturbing side effect. Many children are being grossly neglected by their addicted parents and these same children are being exposed to the harmful side effects of the production of the drug if they live in close proximity to a lab.

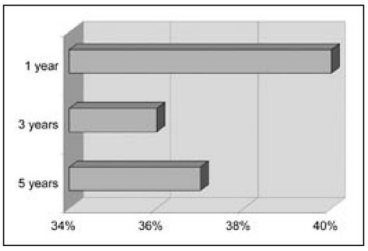
In order to determine the impact of this drug on children of the meth epidemic, the National Association of Counties conducted a survey of county child welfare officials in the 13 states in the country where this activity is administered at the county level. The telephone survey was conducted by Research, Inc. More than 300 counties in 13 states completed the survey. Through these responses, it is clear that out of home placements of children caught up in the meth epidemic are increasing.

County child placement officials were asked if there had been a major increase in the out of home placement of children due to the use or manufacture of methamphetamines starting 5 years ago. Thirty seven percent of the responding officials indicate that there was an increase in that time frame. Although the overall report of an increase was 37%, 54% of counties with populations above 500,000 reported an increase during that time period with the largest increase (69%) reported by the counties in the Southwest. Seventy one percent of responding counties in California reported an increase and 70% of Colorado counties reported an increase for this time period.

For the time period starting three years ago, 36% of responding officials report an increase. Again the counties with populations above 500,000 (64%) reported increases and the Southwest reported the highest (66% of counties). Once again 70% of Colorado counties reported an increase during this time period.

Forty percent of the child welfare officials report increased out of home placements because of meth in the last year. Although this is a subtle increase, it does indicate a growing trend. In the Southwest, 47% of responding officials indicate that they have experienced an increase in the last year. More than 69% of counties in Minnesota reported a growth in out of home placements during this time frame, as did 54% of responding counties in North Dakota.

Figure 4: Increase in Out of Home Placements



Officials in 26% of the responding states estimate that the increase in out of home placements because of meth use, addiction and manufacture was up to 20%, while 4 percent of the counties report an increase of between 75 and 100%.

Seventy five percent of these officials report that up to 20% of the total out of home placements in the last 5 years have been associated with methamphetamine use. In the Northeast, 90% of county officials report up to 20% increase and in the Southeast, 79 percent of county officials report the same percentage increase. In Wisconsin, 100% of the responding officials report increases of up to 20%, while 91% of responding officials in Pennsylvania report the same rate of increase.

The children who are removed from meth homes are often sick and many wind up in foster homes. As these children are moved around in an overburdened social service system, their parents may be in jail, awaiting treatment, or not seeking treatment. County of-

ficials were asked if the particular nature of the meth user parent has increased the difficulty of family reunification and 59% said yes. In Minnesota, 90% of county officials said yes and in California, 86 percent of responding counties gave the same response.

An April 2004 article written by Dan Papin, director of Community Services for Washington County for the Association of Minnesota Counties magazines tells the story. According to Mr. Papin, 30 percent of all child protection assessments in his county involve meth use by family members, the primary reason for the department's involvement, another 25% have some form of meth involvement. He also adds that these children often stay in out-of-home placement three times as long as other children.

The reality, as county officials who have experienced difficulty indicated, is that in 48% of these counties there are more families that cannot be reunified, 56% say the families take much longer to reunify than in the past, and in 27% of the counties, officials say recidivism is so great with meth users that the reunification of these families does not last.

Children who are the victims of the methamphetamine epidemic are presenting many unique challenges to social service workers, foster parents, counselors and adoption workers. As a result, 69% of the responding officials from county social service agencies indicate that their counties have had to provide additional and special training for their welfare system workers and have had to develop new and special protocols for workers to address the special needs of these displaced children.

The Methamphetamine Epidemic

In the past 70 years, a new group of drugs have appeared on the horizon. These are not drugs like heroin, marijuana, and cocaine, but rather the synthetic drugs that use amphetamines as a primary ingredient in their manufacture. Known collectively as methamphetamine, they have been nicknamed meth, crank, crystal, speed and many other local or regional variations.

Originally marked to treat nasal congestion, methamphetamine also became widely used for treatment of narcolepsy and attention deficit hyperactivity disorder. During World War II, the drug was distributed to soldiers to keep them on the move. In the years after the war both Dexedrine and Methedrine became widely available over the counter drugs. As the usage expanded, they became used by long haul truckers to stay awake, by weight conscious Americans trying to lose weight, by athletes to extend their abilities and to treat depression. As the use of the drugs in this category spread, so did the number of people who became addicted.

In response to this addiction, in 1965 the federal food and drug laws were amended to try to decrease the black market sales of amphetamines. The amendments removed many amphetamine products from the market and made others available only by prescription. As a result of the continuing demand for the drugs, illegal laboratories grew. During this same growth, methamphetamine laboratories started to appear on the West Coast. As these illegal labs have grown they have become the major source of illegal methamphetamines.

For many years meth has been imported into the United States from Mexico, and more recently from Canada, China and Southeast Asia. It is also being made locally in major or "super labs" from bulk quantities of chemicals either smuggled into the country or purchased locally. These super labs were capable of making more than 10 pounds of meth a day. The production started to change significantly about 10 years ago when local law enforcement officials started seeing a proliferation of small labs where meth cooks created small amounts of meth from legally purchased household goods using one of more than 100 recipes available on the Internet. Although producing no where near the quantity of meth produced by the super labs, these labs create huge problems for the communities where they are located.

The process of producing meth uses toxic and hazardous materials and produces explosive chemicals as byproducts of the production. These labs affect the environment, the communities and any children, who are frequently present.

The small lab methamphetamine production and market was originally dominated by motorcycle gangs and local producers chiefly in California and the Pacific northwest, but has grown now to include major producers in Mexico who are responsible for the organized trafficking of meth and by the thousands of small producers in nearly all areas of the country. Labs are found just about everywhere, including rural areas, city and suburban residences. Meth can be manufactured in barns, garages, back rooms of businesses, apartments, hotel and motel rooms, storage facilities, vacant buildings and vehicles. A makeshift lab can fit into a suitcase.

What makes this drug epidemic different from others of the 20th and 21st century, is how it started and who is using meth. Meth drug users generally fit two profiles. These are high school and college age students and white and blue collar workers and the unemployed in the age ranges between 20s and 30s in rural and emerging urban areas. Use is equally divided between males and females, and although use is increasing in Hispanic and Native American communities, it has largely been confined to majority white communities. Because meth can be smoked, snorted, injected intravenously, ingested orally or eaten, there are many users who see it has a convenient way to get high.

The growth of the methamphetamine industry in this country has been from the local levels, largely through small labs. Local county law enforcement officials were among the first to recognize the impacts and effects of this new drug on their communities. Western and Midwestern sheriffs and police chiefs were fighting the meth wars long before it became a national problem. The impact of meth addiction on many of these communities has been enormous.

The Criminal Effect of Meth on Communities' Law Enforcement

As you may know, methamphetamine use has risen dramatically in counties across the nation. Formerly a rural problem, it is slowly moving into a more urban setting. At the same time, it has not yet arrived on the national radar screen. The National Association of Counties is conducting a telephone survey of public safety officials in counties to determine the impact of meth use on public safety activities. Can you take a few minutes to answer a few questions that will provide information for a national report that will be released in July?

1. Have arrests where methamphetamine was involved increased in your county?
Yes, in the last 5 years .... 88% Yes, in the last 3 years87% Yes, in the last year 67%

2. In your best estimate, what percentage of the total arrests made in your county in the last five years are methamphetamine related?
0 to 10% .... 36% 10 to 20% .... 15% 20 to 30% .... 11% 30 to 40% 10%
40 to 50% .... 75% 50 to 75% .... 12% 75 to 100% 5%

3. Based on drug related arrests in the last year, which of the following drugs is the biggest problem in your county?
Cocaine .... 19% Heroin .... 3% Marijuana .... 17% Methamphetamine 58%
Others ....

4. Does your county facilitate or sponsor a methamphetamine rehabilitation center or program?
Yes ....16% No 81%

5. What percent of current county jail inmates are incarcerated because of methamphetamine related crimes?
0 to 10% .... 37% 10 to 20% .... 13% 20 to 30% .... 11% 30 to 40% 8%
40 to 50% .... 5% 50 to 75% .... 11% 75 to 100% 6%

6. Have methamphetamine lab seizures increased in your county in the last three years?
Yes ....62% No 35%

7. Has the use of methamphetamines in your county increased the workload of public safety staff?
Yes ....82% No ....18% *If no, skip to #9*

8. If workloads has increased which of the following are happening (check all that apply).
Paying more overtime .... 52% Longer shifts 11%
Changed work assignments .... 13% None of the above 6%

9. Have any of the following crimes increased because of the presence of methamphetamines in your county?
Domestic violence .... 62% Simple Assault .... 53% Robbery or Burglary 70%
Identity Theft .... 27% Don't Know ....

10. Has your county established an interagency special task force to address methamphetamine issues?
Yes .... 52% No, but plans are in the works .... >1% No 40%

11. Is your county a part of an intergovernmental or regional task force to address methamphetamine issues?
Yes .... 60% No, but plans are in the works .... No 35%

The Impact of Meth on Children Out of Home Placement

Methamphetamine use has risen dramatically in counties across the nation. Formerly a rural problem, it is slowly moving into a more urban setting. At the same time, it has not yet arrived on the national radar screen. The National Association of Counties is conducting a telephone survey of counties in states that handle child welfare issues to determine the impact of meth use on out of home placements and other child welfare issues. Can you take a few minutes to answer a few questions that will provide information for a national report that will be released in July?

1. Has your county/state experienced an increase in out-of -home placements in the last year due to the use and manufacture of methamphetamine?
Yes, in the last 5 years .... 37% Yes, in the last 3 years .... 36% Yes, in the last year .... 40% No 49%
If no, skip to Question #3

2. If yes, can you provide an estimate of the amount of this increase?
0 to 10% .... 20% 10 to 20% .... 6% 20 to 30% .... 7% 30 to 40% 4%
40 to 50% .... 3% 50 to 75% .... 3% 75 to 100% .... 4% Cannot provide 5%

3. In your best estimate, what percentage of the total out-of-home placements in the last 5 years have been associated with methamphetamine use?
0 to 10% .... 69% 10 to 20% .... 6% 20 to 30% .... 5% 30 to 40% 4%
40 to 50% .... 2% 50 to 75% .... 3% 75 to 100% .... 2% Cannot provide 6%

4. Has methamphetamine use increased the difficulty of family reunification?
Yes .... 59% No .... 37% Don't know 5%
If no, skip to Question# 6

5. If yes, which of the following apply?
More families that cannot be reunified .... 48% Takes longer to reunify the families 56%
Family reunification does not last .... 27% Other ....

6. Has your county had to develop additional training and special protocols for county welfare workers who work with children who have been exposed to methamphetamine?
Yes .... 69% No 29%

Responding County Law Enforcement Agencies

By State	
Alabama	4
Alaska	5
Arizona	3
Arkansas	9
California	10
Colorado	19
Florida	4
Georgia	26
Idaho	10
Illinois	22
Indiana	16
Iowa	22
Kansas	18
Kentucky	13
Louisiana	7
Maine	1
Maryland	3
Michigan	5
Minnesota	12
Mississippi	19
Missouri	20
Montana	21
Nebraska	19
Nevada	5
New Hampshire	3
New Jersey	1
New Mexico	8
New York	5
North Carolina	13
North Dakota	11
Ohio	9
Oklahoma	7
Oregon	13
Pennsylvania	12
South Carolina	5
South Dakota	16
Tennessee	10
Texas	44
Utah	4
Vermont	2
Virginia	16
Washington	11
West Virginia	2
Wisconsin	6
Wyoming	9
Totals	**500**

By Population Range	
500,00 and above	7
250,000 - 499,999	13
100,000 - 249,999	36
50,000 - 99,999	36
25,000 - 49,999	96
10,000 - 24,999	153
below 10,000	159
Totals	**500**

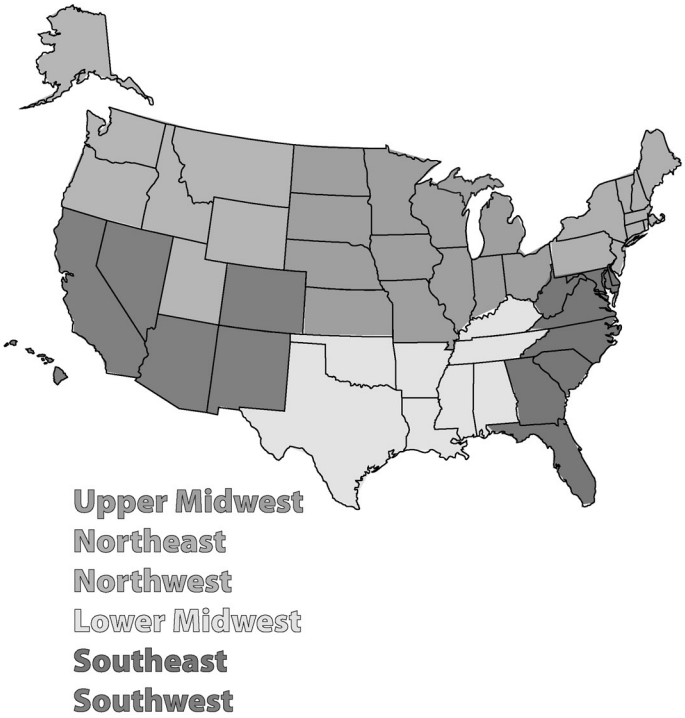
By Regions	
Upper Midwest	176
Northeast	24
Northwest	73
Lower Midwest	113
Southeast	69
Southwest	45
Total	**500**

Responding Child Welfare Agencies

By State	
California	7
Colorado	23
District of Columbia	1
Maryland	1
Minnesota	39
Nevada	2
New York	25
North Carolina	53
North Dakota	28
Ohio	35
Pennsylvania	23
Texas	1
Virginia	35
Wisconsin	30
Total	**303**

By Population	
500,00 and above	11
250,000 - 499,999	13
100,000 - 249,999	27
50,000 - 99,999	48
25,000 - 49,999	85
10,000 - 24,999	66
below 10,000	53
Total	**303**

By Regions	
Upper Midwest	132
Northeast	48
Northwest	0
Lower Midwest	1
Southeast	90
Southwest	32
Total	**303**


Upper Midwest
Northeast
Northwest
Lower Midwest
Southeast
Southwest

LETTER FROM A. BRADFORD CARD, LEGISLATIVE LIAISON, NATIONAL TROOPERS COALITION TO THE HONORABLE MARK SOUDER AND THE HONORABLE ELIJAH CUMMINGS

NATIONAL TROOPERS COALITION

Casey Perry, Chairman
[illegible]
Office Fax: [illegible]
Cell: [illegible]
[illegible]

Brad Card, Legislative Liaison
[illegible] East Squire, NE
Washington, DC [illegible]
Office: [illegible]
Fax: [illegible]
Cell: [illegible]
[illegible]

Michael K. Cunning, Director
Governmental Relations Office
[illegible]
Annapolis, MD [illegible]
Office: [illegible]
Cell: [illegible]
Fax: [illegible]
[illegible]

October 11, 2005

Honorable Mark Souder
Chairman
Subcommittee, Criminal Justice,
Drug Policy and Human Resources
B-373 RHOB
Washington, D. C. 20515

Honorable Elijah Cummings
Ranking Member
Subcommittee, Criminal Justice,
Drug Policy and Human Resources
B-373 RHOB
Washington, D. C. 20515

Dear Chairman Souder and Ranking Member Cummings,

On behalf of the National Troopers Coalition and its membership of State Troopers and Highway Patrolman from across the nation, we write to express our support of **H.R. 3889** the "Methamphetamine Epidemic Elimination Act of 2005."

Methamphetamine has been a very serious law enforcement issue for many years and we recognize H.R. 3889 as a valuable tool in combating this extremely dangerous illicit drug. This legislation recognizes the need to address methods of packaging and distribution for precursors; furthermore, it provides enhanced penalties for those engaged in the trafficking, possession or production of Methamphetamine. We believe the steps taken in H.R. 3889, coupled with increased funding for enhanced drug enforcement, provide our law enforcement community with the necessary tools to effectively fight our nations war on drugs.

We urge your support of H.R. 3889 and we look forward to its enactment into law. Thank you for your consideration.

Respectfully,

A. Bradford Card
(For Casey Perry: Chairman NTC)

SUPPORT YOUR STATE TROOPERS
REPRESENTING OVER 30,000 TROOPERS SERVING 20 MILLION AMERICANS

LETTER FROM DONALD BALDWIN, WASHINGTON DIRECTOR, FEDERAL CRIMINAL INVESTIGATORS ASSOCIATION TO THE HONORABLE HOWARD COBLE

Federal Criminal Investigators Association

Donald Baldwin, FCIA Washington Director
1620 Eye Street, NW Suite 210, Washington, D.C. 20006
Phone 202-331-1275, Fax 202-785-8949

The Honorable Howard Coble, Chairman
House Subcommittee on Crime, Terrorism and Homeland Security
207 Cannon House Office Building
Washington, DC 20515

October 11, 2005

Dear Chairman Coble,

The national office of the Federal Criminal Investigators Association endorses HR 3889, the "Methamphetamine Epidemic Elimination Act of 2005". FCIA believes that passage of this legislation will enhance efforts of the law enforcement/criminal justice system to more easily help put a stop to the illegal use of this dangerous drug.

The FCIA represents the many agents among the nation's 40,000 federal investigators working to control the illegal use of certain precursor chemicals that are often used in the production of Methamphetamine. FCIA believes the increased criminal penalties for trafficking in the production of Methamphetamine is long overdue.

Sincerely yours,

Donald Baldwin
Washington Director

"Dedicated to Recognition of Criminal Investigation as a Profession"

LETTER FROM CHUCK CANTERBURY, NATIONAL PRESIDENT, GRAND LODGE, FRATERNAL ORDER OF POLICE (FOP) TO THE HONORABLE MARK SOUDER

GRAND LODGE
FRATERNAL ORDER OF POLICE®

309 Massachusetts Ave., N. E.
Washington, DC 20002
Phone 202-547-8189 • Fax 202-547-8190

CHUCK CANTERBURY
NATIONAL PRESIDENT

JAMES O. PASCO, JR.
EXECUTIVE DIRECTOR

19 October 2005

The Honorable Mark Souder
Chairman,
Subcommittee on Criminal Justice, Drug Policy
and Human Resources
Committee on Government Reform
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing on behalf of the membership of the Fraternal Order of Police to advise you of our strong support for H.R. 3889, the "Methamphetamine Epidemic Elimination Act." This legislation, which you have introduced along with a number of other congressional leaders in the fight against this deadly drug, greatly complements the provisions of the "Combat Meth Act" as passed by the Senate last month.

As you know, the growth in the use and manufacture of methamphetamines has produced a serious threat in all too many of our communities, and continues its unprecedented spread into previously unaffected areas of the nation. It has created numerous challenges for the communities where it is produced, hazards for the law enforcement officers who must investigate and close down these facilities, and health risks for children who are exposed to its production. In addition, the diversion of precursor chemicals—which are produced overseas, and then smuggled across our borders and into our communities—continues to pose a major problem for law enforcement in its efforts to fight the scourge of meth both here and abroad. Clearly, law enforcement resources must be enhanced if we are to limit the spread of this deadly drug and provide effective controls against the diversion of precursor chemicals.

The legislation that you have introduced addresses this problem correctly by increasing the criminal penalties for the trafficking, possession, and production of meth; enabling the Attorney General to establish domestic production and import quotas for precursor chemicals; reducing the per-transaction sales limit on meth precursors; and providing resources to help prevent the smuggling of methamphetamine into the United States from Mexico. Taken together, H.R. 3889 and the "Combat Meth Act" as passed by the Senate provide a comprehensive approach to countering the growing threat posed by

methamphetamines. In so doing, these measures are invaluable to our collective effort to disrupt the production and trade in methamphetamines and protect our communities from the scourge of crime and drugs.

On behalf of the more than 321,000 members of the Fraternal Order of Police, thank you for your continuing strong leadership on this important issue. Please do not hesitate to contact me, or Executive Director Jim Pasco, if we can provide you with any additional information or assistance.

Sincerely,

Chuck Canterbury

Chuck Canterbury
National President

CC: The Honorable F. James Sensenbrenner, Jr., Chairman, Committee on the Judiciary
The Honorable Howard Coble, Chairman, Subcommittee on Crime, Terrorism and Homeland Security, Committee on the Judiciary

LETTER FROM WILLIAM J. JOHNSON, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF POLICE ORGANIZATIONS, INC.

NATIONAL ASSOCIATION OF POLICE ORGANIZATIONS, INC.

Representing America's Finest

750 First Street, N.E., Suite 920 • Washington, D.C. 20002-4241

(202) 842-4420 • (800) 322-NAPO • (202) 842-4396 FAX

www.napo.org ~ E-mail: info@napo.org

EXECUTIVE OFFICERS

THOMAS J. NEE
President
Boston Police Patrolmen's Association

MICHAEL J. PALLADINO
Executive Vice President
Detectives' Endowment Association of New York City

MICHAEL J. MADONNA
Recording Secretary
New Jersey State Policemen's Benevolent Association

SEAN M. SMOOT
Treasurer
Police Benevolent & Protective Association of Illinois

JAKE JACOBSEN
Sergeant-at-Arms
Phoenix Law Enforcement Association

SANDRA J. GRACE
Executive Secretary
New Bedford (MA) Police Union

NATIONAL HEADQUARTERS

WILLIAM J. JOHNSON
Executive Director

October 4, 2005

The Honorable F. James Sensenbrenner, Jr.
Chairman
Committee on the Judiciary
United States House of Representatives
2138 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Sensenbrenner:

On behalf of the National Association of Police Organizations (NAPO), representing 236,000 rank-and-file police officers from across the United States, I would like to thank you for sponsoring H.R. 3889, the "Methamphetamine Epidemic Elimination Act," and advise you of our support for the legislation. If enacted, this legislation will assist state and local law enforcement in their efforts to crack down on methamphetamine dealers.

Because pseudoephedrine is found in many over the counter cold and sinus medicines such as Sudafed, meth cooks are able to purchase the ingredient in large quantities. The "Methamphetamine Epidemic Elimination Act" will address this problem by reducing the purchasable amount of medicines that contain precursor chemicals that can be used in the production of Methamphetamine. The legislation will also establish procedures that will allow United States law enforcement to better track the shipment of precursor chemicals into the country. H.R. 3889 is an important first step in fighting against the abuse and trafficking of methamphetamine.

NAPO looks forward to working with you to fight for this legislation's passage and I thank you for your continued support of law enforcement. If you have any questions, please feel free to contact me, or NAPO's Legislative Assistant, Andrea Mournighan, at (202) 842-4420.

Sincerely,

William J. Johnson
Executive Director

The National Association of Police Organizations (NAPO) *is a coalition of police unions and associations from across the United States that serves to advance the interests of America's law enforcement through legislative and legal advocacy, political action and education. Founded in 1978, NAPO now represents more than 2,000 police unions and associations, 236,000 sworn law enforcement officers, 11,000 retired officers and more than 100,000 citizens who share a common dedication to fair and effective crime control and law enforcement.*

PREPARED STATEMENT OF THE THERAPEUTIC COMMUNITIES OF AMERICA (TCA)

Therapeutic Communities of America respectfully requests that this written statement become part of the official record for the hearing held before the House Judiciary Subcommittee on Crime, Terrorism, and Homeland Security on September 27, 2005 on H.R. 3889, the Methamphetamine Epidemic Elimination Act. TCA commends the Chairman and the Committee for their leadership in holding a hearing on this important issue.

METHAMPHETAMINE AND THERAPEUTIC COMMUNITIES

Therapeutic Communities of America (TCA), founded in 1975 as a non-profit membership association, represents over 500 community-based non-profit programs across the country dedicated to serving individuals with substance abuse and co-occurring mental health problems. Members of TCA are predominately publicly funded through numerous federal, State, and local programs across multiple agency jurisdictions.

TREATING METHAMPHETAMINE ADDICTION

Therapeutic communities have been successful in helping many addicted individuals, often thought to be beyond recovery, secure a way out of self-destructive behavior. There is a misunderstanding, mentioned several times during the hearing, that methamphetamine addiction cannot be treated. Methamphetamine can and is being treated successfully, both in TCA member programs and by other treatment providers.

Historically, therapeutic communities have been extremely effective at adapting their programs to provide effective treatment as drug use trends change, and in this respect, the current methamphetamine epidemic is no different. Therapeutic communities and other treatment providers have found success in creating special protocols to deal with the unique challenges that methamphetamine addicts present, while treating them with the general population of patients addicted to other drugs of choice. No less than Dr. Nora Volkow, the Director of the National Institute of Drug Abuse, has noted that "methamphetamine addiction can be treated successfully using currently available behavioral treatments."

Counselors at several TCA member therapeutic communities that treat a high volume of meth users have recorded long-term abstinence rates for their patients of between 30–50%. These numbers are not much different from typical long-term abstinence rates for treating alcohol and other drugs. In the words of a clinician from a TCA member program, "Overall success rates have been the same or better in our programs after the meth wave came as compared to before. Meth users initially experience some cognitive deficits, but otherwise there is not much of a difference between them and other users."

TCA RECOMMENDATIONS

While TCA strongly commends H.R. 3889's focus on methamphetamine abuse, we believe that this bill could be greatly strengthened with provisions providing for methamphetamine treatment funds. The *2002 National Survey on Drug Abuse and Health Report* stated that only 18.2 percent of all Americans over the age of 12 needing treatment actually received it. Along with enhanced law enforcement capabilities and interdiction efforts, evidence-based treatment services provide a valuable tool in fighting the growing methamphetamine epidemic. Treatment funds are especially crucial because of the nature of the meth epidemic—the drug is mostly present in rural communities, where evidenced-based treatment services tend to be scarce or limited.

TCA also recommends that H.R. 3889 include a component that encourages NIDA to undertake further research on effective modalities for treating methamphetamine addiction. Lastly, TCA respectfully requests that the Committee recognize the benefits of treatment as part of the solution to eradicating the methamphetamine epidemic from our communities, and strongly encourages the Judiciary Committee to work with the relevant committees with jurisdiction over substance abuse treatment to add provisions that support treatment to this important piece of legislation.

PREPARED STATEMENT OF THE FOOD MARKETING INSTITUTE (FMI)

INTRODUCTION

The Food Marketing Institute (FMI), on behalf of the nation's supermarkets and grocery stores, appreciates the opportunity to provide testimony to the House Judiciary Subcommittee on Crime, Terrorism and Homeland Security in response to the issue of methamphetamine abuse in the United States and legislation that is designed to combat the problem.

By way of background, FMI is a national trade association that conducts programs in research, education, industry relations and public affairs on behalf of its 1,500 member companies—food retailers and wholesalers—in the United States and around the world. FMI's members operate approximately 26,000 retail food stores with combined annual sales of $340 billion—three quarters of all food retail store sales in the United States. FMI's retail membership is composed of large multi-state chains, regional companies and independent grocery stores. Our international membership includes some 200 companies from 50 foreign countries.

As reflected in our testimony presented by Joseph R. Heerens, Senior Vice President, Government Affairs, Marsh Supermarkets, Inc., before the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources on November 18, 2004, the supermarket industry fully understands the magnitude of the methamphetamine problem here in America, and we also recognize the sad fact that legitimate cough and cold products containing the ingredient pseudoephedrine (PSE) are used to make methamphetamine.

According to law enforcement sources, legitimate PSE products either purchased or stolen from retail stores account for approximately 20 percent of methamphetamine that is made domestically here in the United States, whereas the lion's share of meth found in this country, an estimated 80 percent, comes from foreign sources, primarily super labs located in Mexico. Thus, it is FMI's view that to effectively address the methamphetamine problem we need a comprehensive strategy and partnership between law enforcement, regulatory agencies, OTC manufacturers and the retail community.

SCHEDULE V—SUPERMARKET CONCERNS

The supermarket industry has serious concerns and misgivings over recent initiatives that have been enacted into law at the state level and pending federal legislation (S. 103-H.R. 314) that impose stringent controls on precursor chemicals at the retail level. We are referring to what is called the Oklahoma model that relegates PSE products to Schedule V status. Under this approach, only retail stores that have a pharmacy department are allowed to sell these OTC medications, and these items must be kept behind the pharmacy counter.

Without question, Schedule V is very troublesome to our industry. That's because an overwhelming majority of grocery stores doing business in the United States don't have a pharmacy department and would be precluded from selling PSE products. For those supermarkets that do have a pharmacy department, store hours are quite different from hours of operation in the pharmacy department. For example, while supermarkets may be opened from 7:00 am to 11:00 pm, the pharmacy department operates on an abbreviated schedule and may only be open from 9:00 am to 9:00 pm weeks days, 9:00 am to 7:00 pm on Saturday and 11:00 am to 5:00 pm on Sundays. Thus, even though the grocery store is open for business, if the pharmacy department is not open, or if the pharmacist is not on duty, PSE product sales would not be permitted.

IMPACT ON CONSUMERS

The end result under the rigid Schedule V approach is a dramatic reduction in consumer access to cough and cold medications depending upon whether their local grocery store has a pharmacy department and what hours the pharmacy department is opened on a particular day. For consumers living in rural areas or in inner city communities, Schedule V can create major hardships if the nearest pharmacy is 15 to 20 miles from their home or if the person is elderly or poor and would have to rely on public transportation in order to get to a pharmacy to purchase PSE products.

FMI along with the National Consumers League (NCL) gauged consumer opinion and views on sales restrictions of PSE products in a national survey that was released in April of 2005. What the FMI-NCL survey found is rather revealing. Forty four percent of the 2,900 adult survey respondents felt that Schedule V would create a hardship for them, while 62 percent said they did not believe that restricting sales of PSE products to pharmacies is a reasonable measure for controlling meth produc-

tion. In stark contrast, the survey respondents were far more receptive to less severe restrictions to Schedule V, such as placing cough cold and allergy products behind a counter, not a pharmacy counter, or placing them in a locked display case. Additionally, more than 80 percent of the survey participants expressed support for limiting the quantity of such products that individuals can purchase, and 74 percent said it would be reasonable to restrict the age of purchasers.

For the above mentioned reasons, FMI and our members cannot support a Schedule V classification for cough and cold products containing pseudoephedrine. Schedule V clearly poses significant problems for consumers who have legitimate needs for these medications to treat their allergies, coughs and colds. Schedule V means reduced consumer access and hardship because their nearby grocery store, which they visit 2.2 times per week, won't be allowed to sell these items. FMI further suspects that Schedule V may mean higher prices as PSE products move from self-service to behind the pharmacy counter, where the pharmacist, a highly salaried professional, will be required to ask for photo identification and have the customer sign a log book. While our industry applauds the hard work of the law enforcement community in their efforts against the methamphetamine plague, we do not believe Schedule V is the right solution.

COMBAT METH ACT OF 2005 IS FLAWED

In terms of pending federal legislation, the Combat Meth Act of 2005 (S. 103) approved by the Senate on September 9, 2005, as part of the FY 2006 Commerce/Justice Appropriations, FMI firmly believes that this proposal is both deficient and flawed, and in need of significant revisions. The following are the deficiencies and flaws that we see in this legislation:

- S. 103 fails to provide for a national standard governing the sale of PSE products. Methamphetamine is a nationwide problem that necessitates a national solution. Regrettably, S. 103 allows states and well as localities to establish different restrictions on the sale of PSE products, making compliance by retailers more difficult and complicated.
- The Combat Meth Act of 2005 does not exempt liquids and gel caps even though every state Schedule V law regulating the sale of PSE products exempts liquids and gel caps.
- Unless the Combat Meth Act of 2005 is amended, it will trigger a *"by prescription only"* requirement in as many as 19 states. This would mean consumers would have to get a prescription from their doctor in order to purchase PSE products. As a result, a product that normally sells for about $6.00 at retail will now cost close to $60 when you factor in the physician office visit charge.
- Moreover, the Schedule V provisions in S. 103 will force grocery warehouses and distribution centers that handle PSE products to apply for a Controlled Substances Registrant license from the Drug Enforcement Administration (DEA). This will entail higher licensing fees and new regulatory burdens for these facilities. Imposing Schedule V requirements and costs on warehouses and distribution centers makes no sense since these facilities are not a source of supply for meth cooks.
- S. 103 is too narrow. It only addresses 20 percent of the problem in terms of domestic meth production resulting from PSE products that have been obtained or stolen from retail stores. S. 103 does nothing to address 80 percent of methamphetamine that finds its way into the United States from foreign countries.
- The Combat Meth Act of 2005 dramatically and unfairly reduces consumer access to cough and cold products by limiting their sale to stores that have a pharmacy. PSE products would have to be placed behind a pharmacy counter. Moreover, due to space limitations in the pharmacy, retailers will not be able to carry and offer for sale the wide variety of PSE medications that consumers want or need, and because these products will be behind the pharmacy counter, consumers will no longer have the opportunity read and compare product labels.
- The Combat Meth Act of 2005 limits purchasers to no more than 7.5 grams within a 30-day period. This arbitrary limit may be unfair to a family with allergy problems or a parent with several sick children who has a legitimate need for more than 7.5 grams within a 30-day period.
- S. 103 is cavalier in its treatment of internet sales and flea markets. The legislation allows but does not require the Attorney General to promulgate regu-

lations governing the sale of PSE products over the Internet. Furthermore, S. 103 has no provisions relating to flea markets which routinely sell PSE products that in most cases have been stolen from retail stores by organized theft gangs. Flea markets should be precluded from selling PSE products unless these transient vendors have written authorization or appropriate business records from the manufacturer.

- S. 103 allows stores without a pharmacy department to sell PSE products under very limited circumstances. The exemption process is so complicated and convoluted involving both state and federal agencies. It is our view that very few exemptions will be granted and they will not be granted in a timely fashion.
- The implementation dates for Schedule V are unrealistic. For example, single ingredient PSE products would be placed in Schedule V 90-days after enactment and retailers would be required to maintain a log book. It is highly unlikely that the Department of Justice (DOJ) would be able to promulgate necessary regulations in 90-days to tell retailers how to comply with the law.

FMI SUPPORTS METH EPIDEMIC ELIMINATION ACT

FMI wishes to express our industry's support for the Meth Epidemic Elimination Act (H. R. 3889) that has been introduced by Representatives James Sensenbrenner (R-WI), Mark Souder (R-IN), Chairman Howard Coble (R-NC) and Roy Blunt (R-MO). Unlike the narrow focus of the Combat Meth Act of 2005, this initiative seeks to address the methamphetamine problem in a comprehensive manner. The legislation is multi-faceted with provisions that would establish domestic as well as international regulation of precursor chemicals while providing for more severe penalties for methamphetamine production, possession or trafficking.

In expressing our industry's support for the Meth Epidemic Elimination Act, we would urge the Subcommittee to make the following changes:

- Amend the bill to include strong federal pre-emption language governing the sale the PSE products in order to facilitate retailer compliance, or at the very least prohibit local communities from implementing restrictions that are different from sales restrictions that have been established by a state.
- Revise the legislation from a 3.6 gram per single transaction to 6 grams per transaction.
- Establish a ban on Internet sales of precursor chemicals.
- Prohibit flea markets from selling PSE products as well as infant formula unless these transient vendors have written authorization from the manufacturer.

FMI, on behalf of the nation's supermarket, appreciates the opportunity to provide testimony on this important issue to the Subcommittee.

PREPARED STATEMENT OF THE AMERICAN COUNCIL ON REGULATORY COMPLIANCE

The American Council on Regulatory Compliance is an association especially established for small and mid-size manufacturers, distributors and retailers of over-the-counter medicines and preparations containing List I chemicals that are regulated by the US Drug Enforcement Administration (DEA). Although this constitutes a very diverse group of businesses both in size and activity, they nevertheless share certain common regulatory concerns by virtue of distributing these products.

Although many such businesses may be members of other associations, no one single association addresses this situation in depth. The commerce in these registered products serves the legitimate requirements of millions of consumers. The American Council on Regulatory Compliance and its members recognize and accept the importance of regulating these products in order to assure proper use. They support the state and federal government, and particularly the US Drug Enforcement Administration in this important effort. Although this effort involves concerns and continually changing issues to the business community, it is essential that government and business establish the maximum level of cooperation and communication.

THE ACRC COOPERATES WITH CONGRESS AND FEDERAL AGENCIES

The American Council on Regulatory Compliance is dedicated to cooperating with the U.S. Congress, Federal regulatory and law enforcement agencies, such as the Drug Enforcement Administration, State and Local Authorities, and other organizations to help prevent illegitimate use.

The ACRC encourages all members to improve training and compliance activities and to establish constructive partnerships at all levels of government. The association supports the following initiatives:

(1) Compliance training for Members;

(2) Assisting with education and compliance at the retail level;

(3) Developing security and record keeping models;

(4) Implementing a system for screening orders and monitoring sales.

(5) Promote understanding of laws and regulations.

"METHAMPHETAMINE EPIDEMIC ELIMINATION ACT"

The ACRC supports the overall thrust and spirit of H.R. 3889 and believes that it addresses a major problem of illicit Methamphetamine use through import controls and increasing penalties for the illicit production of Methamphetamine. However, there are provisions of the bill that could be modified to improve and clarify the legislation.

Current law, Title 21, United States Code (21 USC), Section 971 (c) (1), allows the Drug Enforcement Administration (DEA) to disqualify customers of a List I Chemical Importer, if the List I Chemical may be diverted to the clandestine manufacture of Controlled Substances. This is achieved by providing written notice to the Importer. After the Importer has given notice of their intent to import, they are not permitted to continue the transaction. The Importer registrant is then entitled, by written request, pursuant to 21 USC 971(c) (2) to an administrative hearing within 45 (forty-five) days, to challenge the DEA's allegations.

Currently, the law specifies that a challenge can only be made by whom the order applies. Thus, there is a dispute as to whether the wholesaler or downstream customer of the Importer can challenge DEA's allegations against them. Heretofore, DEA, with the exception of situations in which they have been challenged in District Court, have not given "standing" to customers of the Importers. The new legislation language codifies DEA's position of not giving "standing" to customers of the Importer. This procedure, and the current approach taken by DEA, does not give the right of the accused to face their accuser in an administrative hearing to challenge the DEA allegations. The limited times, it seems, that DEA has been challenged by the downstream customer, in lieu of the Importer registrant, appears to the outsider, to have been mired in court actions, appeals and continued objections by DEA.

Section 104 of H.R. 3889 (lines 6 through 10) seeks to place ephedrine (EPH),

Pseudoephedrine (PSE) and Phenylpropanolamine (PPA) within the same statute that currently applies to Schedule III-V Narcotic Controlled Substances. (This could be modified to apply to the creation of a special statute section for the listed chemicals PSE, EPH and PPA.)

The significant questions posed by the provisions of H.R. 3889 are:

- Under what criteria will imported quantities of EPH, PSE and PPA be determined?
- Who will decide the legitimate use in the U.S. for PSE, EPH and PPA—DEA or FDA?
- Will convenience stores, which DEA classifies as "gray market" distributors, be entitled to continue dispensing products that contain PSE, EPH and PPA?
- Will retail restrictions be used by DEA to tabulate retail quantities to limit imports?

The proposed legislation in lines 15–26 on page 7 and continued in lines 1–20 on page 8 address only the right of Importers to have legal standing. It does not address the needs of downstream customers of the Importer registrants. If the Importer wishes not to challenge the downstream customer, i.e. distributor or retailer, his customer has no "standing".

Section 105 defines the conditions by which an Importer registrant must adhere, if their initial customer does not purchase the import they originally requested. This language subjects the new customer, if any, to the aforementioned scrutiny of possible denial, again based upon only a challenge by the Importer registrant.

RECOMMENDATIONS

We do not dispute the need to control the Importation of Listed Chemicals, especially

with majority of the problem being illegal importation. However, the downstream customers of Importer registrants have no legal standing to challenge DEA's allegations they are using listed chemicals PSE, EPH and PPA illegitimately "on the

grounds that the listed chemical may be diverted to the illegal or clandestine manufacture of a controlled substance". DEA has long held the opinion that convenience stores selling cold remedies containing EPH, or EPH are not legitimate retail distributors ("gray market").

If not modified, certain provisions of this bill could be construed to limit sales of legitimate cold remedies to small stores by arbitrarily limiting imports to Distributor registrants that sell to small retail establishments. In many administrative hearings, DEA has used past retail sales history of cold products as evidence that the store is engaged in the illegal diversion of pseudoephedrine, even if the store increases retail sales in a legal manner.

Recent enactments of state law also pose a problem. Liquid gel cap forms of listed chemical drug products that have been exempted from Schedule V requirements under state law could be cumulatively aggregated together in import quotas and applied against small retail distributors. In such a case, retail establishments would not have standing to protest arbitrary restrictions of their supply of medications.

PROPOSED REVISIONS

1. EPH, PSE and PPA should not be subjected to the same statutory scrutiny as controlled drugs in Schedule III-V Narcotics for purposes of importation as proposed on page 7. There is sufficient legislation currently in place under the provisions of 21 USC, Section 971 that govern imports of listed chemicals.
2. Under the provisions of the proposed new section (d)(1) there are no rights given to a registrant (distributor) or business exempted from registration (convenience store). The only rights are given to the Importer registrant to object to DEA's denial. Importer registrants will be persuaded not to object to challenges, as they are now, for future considerations in the marketplace.
3. Title 21, Section 971 should be amended in all proper places, by the insertion of language to expand the rights of the customer of the Importer registrant, which are the distributor, dispenser or business exempt from registration (retail stores not registered as a pharmacy). All rights of the customers of the Importer registrant should be delineated, to provide for the expectations of all registrants to be permitted to face their accuser.

ARTICLE ENTITLED "THE MEXICAN CONNECTION," STEVE SUO, JUNE 5, 2005, *THE OREGONIAN*, SUBMITTED BY THE HONORABLE ROBERT C. SCOTT

Help
Return to Headlines

LOCAL STORIES

THE MEXICAN CONNECTION

STEVE SUO - The Oregonian Freelance journalist Adrienne Bard contributed to this report in Mexico
3,912 words
5 June 2005
The Oregonian
SUNRISE
A01
English
Copyright (c) 2005 Bell & Howell Information and Learning Company. All rights reserved.

MEXICO CITY

Summary: Huge increases in imports by Mexico of the key chemical in making meth signal a switch in strategy by drug cartels to move labs south of the border

America's methamphetamine crisis is now rooted in Mexico, where drug cartels are illicitly obtaining tons of pseudoephedrine, the key ingredient needed to make the potent stimulant.

Mexico's imports of the cold medicine have vaulted from 66 tons to 224 tons in the past five years, customs records show. That's roughly double what the country needs to meet the legitimate demands of cold and allergy sufferers, an analysis by The Oregonian found.

U.S. officials say meth production in Mexico is rising because Mexican traffickers can no longer easily obtain pseudoephedrine in the United States and Canada, which have cracked down on companies that sell cold pills. The number of Mexican-run "superlabs" found in California has plummeted in the past three years, the officials say, yet Mexican-made meth remains widely available on the streets of the United States.

Although some U.S. officials predicted three years ago that traffickers would start acquiring pseudoephedrine in Mexico, the United States and Mexico failed to prevent it from happening.

U.S. officials say they have been talking to the Mexican government about the country's surging imports of pseudoephedrine powder since 2003.

However, those discussions have largely taken place among officials below the Cabinet level. Senior U.S. law enforcement officials have not raised the issue in public testimony before Congress.

Mexican authorities have moved to restrict the number of cold pills consumers can buy, to confine sales to

pharmacies and to shut down a number of distributors. But only this year is Mexico beginning to roll back the amount of pseudoephedrine that companies can import.

Mexican officials have told the U.S. Drug Enforcement Administration that they have reduced their import quota 30 percent this year. That reduction, U.S. officials say, applies to 2004 import levels.

But the change has not had much effect so far. Mexican customs data show pseudoephedrine imports total a little more than 69 tons through April, putting the country on a pace to import 210 tons by year's end. That's almost as much as the 224 tons imported in 2004.

DEA officials said the Mexican government is trying to curtail the volume by imposing a temporary moratorium on new import permits, but permits issued in 2004 may continue to allow shipments to enter the country.

Even if Mexico achieves a 30 percent reduction in imports this year, the new import level would still leave traffickers a surplus of 28 to 65 tons to obtain the pseudoephedrine they need, The Oregonian's analysis shows.

The newspaper's analysis, drawn from demographic data and independent market research, offers the first publicly available estimate of how much cold medicine Mexico legitimately needs. The analysis suggests that Mexico's legitimate demand is between 90 and 130 tons -- roughly 100 tons less than the country imported last year.

The Oregonian's assessment includes data from one of Mexico's largest discount pharmacy chains and other industry sources. Some statistics, such as precisely how much pseudoephedrine is distributed by public health agencies, could not be directly obtained.

Mexican health officials have told international authorities that the country's legitimate demand may be as low as 70 tons, or a third of what Mexico imported in 2004. That estimate was presented as tentative, and the Mexican government is still refining it.

The International Narcotics Control Board in Vienna, Austria, which tracks the global drug trade, is examining Mexico's pseudoephedrine imports and suspects the recent increases cannot be explained by the legitimate market.

In the United States, DEA officials say they have not calculated Mexico's legitimate demand. They do not know whether Mexico's planned import reductions will be enough to eliminate illegal diversion.

New volume in U.S.

The failure to halt diversion of pseudoephedrine products made in Mexico has profound consequences for cities and towns across the United States.

U.S. law enforcement officials report the cartels are making new inroads in the United States, setting up methamphetamine distribution hubs as far east as Atlanta.

"We had bad problems with the mom-and-pop labs, but 50 mom-and- pop labs aren't half of one of these

shipments we're seeing here," said David Nahmias, U.S. attorney for the Northern District of Georgia. The Mexican cartels will replace the meth supplied by local labs, Nahmias predicted, "with double the volume, double the purity, double the quality."

Superlabs in Mexico, which DEA officials say produce half the meth sold in the United States, cannot sustain their market of 1.3 million users without acquiring massive quantities of the drug's essential ingredients.

"Unnecessary Epidemic," a series of articles on methamphetamine in The Oregonian last year, revealed that ephedrine and pseudoephedrine originate in only nine major factories around the world. The series showed that restricting the flow of these chemicals can force traffickers to cut meth production. The drug becomes more expensive and less potent, and users quit.

But U.S. authorities have been unable to maintain the pressure because traffickers simply rerouted their pseudoephedrine purchases to countries with weaker controls.

"It's only natural that they would seek the path of least resistance, or less resistance," said Scott Collier, the DEA's chief of dangerous drugs and chemicals.

Even as Mexico begins to tighten access to the chemical, traffickers may be exploring new routes: Argentina's imports of bulk pseudoephedrine doubled from 2000 to 2003, Colombia's tripled, and Indonesia's rose tenfold.

"It doesn't take a genius to see that you can go south of Mexico, and there are opportunities in every country in Central America and South America to do a similar thing," Collier said.

U.S. and Mexican officials acknowledged in recent interviews that there's a problem with Mexico's rising pseudoephedrine imports, but they differed over its severity.

Mexican officials say the country's consumers are demanding more cold medicine as their economy grows. Jose Luis Santiago Vasconcelos, Mexico's top drug prosecutor, said the cartels are obtaining only small amounts of pseudoephedrine from the domestic pharmaceuticals industry. "The legal market is not the main source," he said.

However, Harry J. Matz, a senior trial attorney and expert on chemical control at the U.S. Justice Department, said diversion of Mexican-made cold pills "is obviously fueling the explosion in meth labs in Mexico."

A vulnerable portal

Above the customs house at Mexico City's Benito Juarez International Airport, a guard watches closely as a forklift moves pallet after pallet of barrels from a caged section of the warehouse into the back of an armored truck.

The sensitive cargo is part of a three-ton shipment of pseudoephedrine from India. A mounted video camera swivels to follow the armored truck as it heads for the front gate.

This amount of pseudoephedrine landed in Mexico every five days in 2004, with the paperwork on each shipment checked by the health minister, the attorney general, Mexico's consulate in the exporting country

and the International Narcotics Control Board.

The deliveries are typically arranged by chemical brokers who bring the raw material into the country. Then the pseudoephedrine is bought by pharmaceutical companies, which make it into cold pills. The medicine is sold to wholesalers, who supply the nation's pharmacies.

At each step, the transactions are overseen by government authorities under a 1997 Mexican law that requires reports and thorough record-keeping for companies that handle drug-related chemicals. Officials audit the records and inspect the companies.

Yet somewhere along the line, huge amounts of pseudoephedrine, mostly in pill form, are finding their way to the drug cartels.

The chemical is vulnerable from the moment it leaves the customs warehouse. Last June, not 100 yards from the airport gate, gunmen stole three tons of pseudoephedrine powder -- enough to make 18 million doses of meth -- from a truck parked in an unlocked area. The truck driver had decided to wait overnight to deliver his load to a Mexico City chemicals broker.

The circumstances make Mexican authorities think it was not a "natural" robbery, said Vasconcelos, Mexico's deputy attorney general for organized crime.

"There are a lot of strange things there that I didn't like," Vasconcelos said. "They moved the truck to a place where there were no cameras. People entered, and nobody saw anything, when a lot of people could have seen what was going on."

The intended recipient was the largest importer of pseudoephedrine in the country, Sica S.A. de C.V., whose imports increased from 21 tons in 2000 to 68 tons in 2004. Vasconcelos said investigators are examining why the company's imports have grown so large.

Maria del Rocio Alpuche, a manager at Sica, declined to discuss the theft, Vasconcelos' investigation or the company's patterns of imports. She said Sica's customers "all know us, since we have 40 years in the market in Mexico."

Six companies accounted for 90 percent of Mexico's pseudoephedrine imports in 2004, which came mainly from India, China and Germany. Most of those importers also declined interview requests.

The Mexican subsidiary of BASF, which imports pseudoephedrine from its factory in Germany and sells it to drug companies, said it was impossible any of its product had landed in illegal channels because it is closely regulated.

Asked why BASF's sales in Mexico grew from 10 tons in 2002 to 52 tons in 2004, spokesman John Schmidt said only the company's customers would know the answer. "It sounds to me like you're trying to put the onus on BASF," Schmidt said.

Vanishing pills

The risk of diversion rises after Mexican pharmaceutical companies turn the pseudoephedrine powder into

pills. Sometimes, the cartels buy large quantities of cold medicine from dishonest pharmacies. Other times, they use front companies to buy pills from drug wholesalers.

Mexican authorities said they learned in 2004 that the Mayo Zambada/Chapo Guzman organization, an emerging leader in Mexican meth production, had enlisted a major pharmaceutical wholesaler in Guadalajara.

"What did we find with this distributor?" Vasconcelos said. "That one of its managers was selling large quantities of pseudoephedrine to pharmacies that didn't exist or to pharmacies that did not have the authorization of the secretary of health to sell that type of controlled medicines."

Pharmacies pose an even bigger problem, he said. The government has "constant surveillance over the distributors," Vasconcelos said. "Where it gets more difficult is with the pharmacies on the street, because there you can't have control. They can say they sold 50 cases when they only sold five cases, and the other ones were diverted."

Farmacias Similares, a leading pharmacy chain in Mexico, has rejected a number of suspicious orders. Spokesman Vicente Monroy said a supposed wholesaler last year requested a large load of cold pills containing pseudoephedrine, anti-diarrhea formulas and other medications. The other medicines could wait, the wholesaler said, but he needed the cold pills immediately.

Authorities have confiscated millions of Mexican-made pseudoephedrine pills from airports, buses and meth labs in Mexico.

Victor Clark Alfaro, a Tijuana human-rights advocate who has interviewed numerous meth cooks, said pseudoephedrine pills are readily obtained in the border city. "They always tell me, 'Victor, it's very easy. You can buy from this woman 10,000 boxes,' " Clark said.

Traffickers use sophisticated metallic presses to remove the pills from foil blister packs. The pills are dipped in a solvent to remove inactive ingredients and then transformed into meth.

At least 16 of the roughly 50 pseudoephedrine brands made in Mexico have turned up in the hands of suspected drug traffickers since 2000, reports from Mexican military and police agencies show.

Cold pills made by Productos Farmaceuticos Collins are among the most frequently seized. In March, Mexican police stopped a shipment of 200,000 of the company's Lovarin P cold pills at a delivery service in Mazatlan, one of at least 15 seizures involving Collins' products over the past five years.

The company's imports of pseudoephedrine have risen almost sixfold since 2000, from 3 tons to 17, customs records show. Collins officials did not respond to written questions and telephone calls seeking comment.

A spokesman for Schering-Plough's subsidiary in Mexico, the country's leading seller of pseudoephedrine products, said the company is "extremely concerned" that its Afrinex pills have been confiscated frequently by narcotics officials.

Assistant General Manger Sergio Ulloa said Schering-Plough S.A. de C.V. cooperates with the authorities in every investigation, sells only to well-established distributors and turns away business when it has doubts. The company delivers its product directly to the distributor's warehouse. What happens after that, Ulloa said,

is "something that is out of our control."

Dire consequences

Mexico's pseudoephedrine surplus is fueling a rise in the availability of Mexican meth in new U.S. markets -- a connection illustrated vividly in October, when U.S. investigators linked a meth lab outside Mexico City to a group of traffickers in Atlanta.

Mexican prosecutors said federal police found the lab after arresting three men in a pickup hauling a load of Schering-Plough's Afrinex pills. At the lab was a vehicle with a hidden compartment containing 22 pounds of finished meth, enough for about 100,000 hits. Its destination, Mexican officials said, was points north.

Atlanta is now awash in Mexican-made meth, according to U.S. law enforcement officials. As recently as 2003, federal agents were seizing shipments of 4 to 7 pounds of meth at a time. Last year, it was 20 to 70 pounds.

In January, DEA agents intercepted 125 pounds headed to Atlanta from the border town of Brownsville, Texas. Then, in March, they nabbed 174 pounds. It was one of the largest seizures in U.S. history.

Sherri Strange, special agent in charge of the DEA in Atlanta, said Mexico's Gulf and Armando Valencia cartels are battling for turf in Atlanta. The city has become a command center for distributing the drug from Miami to New York, according to federal law enforcement officials.

"I'm more concerned about this drug than any drug issue in the district or the state," said Nahmias, the federal prosecutor in Atlanta. "We've had this rising tide. Now it's like a tidal wave, and it's about to crash down on us because of the huge amounts we're seeing."

Users are flocking to the Mexican product, frequently referred to as "ice." Georgia's treatment admissions for meth, a leading indicator of the number of users, quadrupled between 2000 and 2003.

Assistant U.S. Attorney Robert McBurney said some Georgia users now ask for meth by the name of their favorite Mexican supplier.

"There's no comparison" with homemade meth, McBurney said. "The stuff that's made in Mexico is a lot better."

Low on the agenda

Mexican drug traffickers have cranked up production of meth unimpeded because Mexico's soaring imports of pseudoephedrine make the chemical easy to obtain. Yet documents, interviews and public testimony show that the growth in imports has caused little stir among top U.S. policymakers.

The topic receives no mention in the DEA's latest unclassified intelligence report on Mexico, published in November 2003; the National Synthetic Drugs Action Plan, published in October; or the U.S. State Department's International Narcotics Strategy Report, published in March.

Robert Charles, chief U.S. diplomat on narcotics issues from October 2003 until March 2005, said he was

never alerted to the problem.

"That's a dramatic uptick," Charles said in April, when told by The Oregonian that Mexico's pseudoephedrine imports had grown from 95 tons in 2002 to 224 tons in 2004. Charles said that if he had seen those numbers while in office, he would have raised questions directly with Mexico's attorney general and senior U.S. officials.

U.S. Attorney General Alberto Gonzales was briefed on the pseudoephedrine imports in April, before meeting with Mexico's attorney general. During a Senate hearing in May, U.S. Sen. Patty Murray, D-Wash., asked Gonzales what the United States was doing to smash the cartels' supply of pseudoephedrine.

Gonzales said that U.S. officials were working with law enforcement in other countries. "And I think we're making some progress," he said. "Obviously, more needs to be done."

Gonzales did not mention the fact that Mexico's legal imports of pseudoephedrine have soared over the past five years.

DEA Administrator Karen Tandy also did not address Mexico's legal pseudoephedrine imports when she was asked about Mexican meth production during congressional testimony in March.

Tandy and other U.S. officials instead have highlighted a smaller source of pseudoephedrine in Mexico: Hong Kong.

DEA officials say drug companies in Hong Kong have illicitly shipped 450 million cold pills to Mexican traffickers since 2003 -- enough to yield 13.5 tons of pseudoephedrine a year. By comparison, The Oregonian's analysis suggests traffickers obtained 95 to 132 tons from products made by Mexico's own pharmaceutical industry.

Mid-level U.S. officials say they are aware of the growth in Mexico's legal imports of pseudoephedrine, which began in 1998, and have been discussing it with their Mexican counterparts.

"We talk to them very frankly about any suspicions we have," said Collier, the DEA's chief of dangerous drugs and chemicals. "I think movement by them on this issue indicates that they do understand and are taking steps, at any rate, to try and at least prevent diversion from the legitimate marketplace."

Diana Page, a U.S. Embassy spokeswoman, said it was the Mexican government that contacted U.S. officials about the country's massive influx of pseudoephedrine. She said Mexican health officials asked for help creating a computer registry of imports and domestic sales, telling U.S. officials, "We know we have a problem."

Charles, the former assistant secretary of state for international narcotics and law enforcement affairs, said the problem has not risen higher on the U.S. agenda with Mexico because of competing concerns such as corruption, immigration and trade. The list is so long, he said, that "no one issue seems to be ever able to fully dominate the discussion."

"More pressure has to be applied to Mexico than has been applied," Charles said. "But you're talking to the guy who believes that the most, versus a trade guy, who would say to you, 'Now, now, now, that's not the No.

1 priority.' "

A moving target

Even if the Mexican government succeeds in clamping down on pseudoephedrine, there is little to prevent traffickers from leapfrogging to other countries for their essential meth ingredient. For more than a decade, the traffickers have done just that, rebounding from each new restriction on meth ingredients by finding sources that U.S. authorities ignored.

Mexico's Amezcua brothers pioneered mass production of the drug in the early 1990s by ordering ephedrine powder direct from manufacturing nations: India, China, Germany and the Czech Republic. When those countries cracked down in 1995, Mexican cartels began buying pseudoephedrine pills in the United States. U.S. officials tightened their rules in 1997, and traffickers turned to Canada, which lacked any restrictions.

Canadian companies began importing dramatically more pseudoephedrine powder, much of which DEA officials say was converted to pills and sold to cross-border smugglers. U.S. officials responded vocally, repeatedly flagging Canada's rising imports in State Department narcotics reports. President Bush and congressional leaders leaned on Canada to act.

What U.S. officials failed to note, at least publicly, was that Mexico's pseudoephedrine imports were also growing. United Nations trade statistics show Mexico's imports of pseudoephedrine matched Canada's increase roughly ton for ton starting in 1998, the year DEA officials pegged as the start of the Canadian boom.

By 2002, a joint report by the DEA, State Department, Central Intelligence Agency, White House drug czar and other agencies theorized what would happen when the Canadian pipeline closed. Mexican traffickers would move production to Mexico, the report said, "where chemicals could be more easily obtained."

DEA agents and the Royal Canadian Mounted Police eventually snared hundreds of smugglers, and Canadian officials enacted new regulations on pseudoephedrine in 2003. The flow of pills from Canada to the United States dried up, while Mexico's imports kept rising.

Facing a shortage of Canadian pseudoephedrine, Mexican traffickers dramatically scaled back production in California. The number of superlabs found in the United States fell from 244 in 2001 to 53 in 2004. U.S. officials say the labs simply moved to Mexico. As a result, shipments of finished meth found moving across the U.S. border grew from 2,600 pounds in 2002 to 4,500 pounds in 2004.

U.S. officials expect other countries to become targets for the cartels as Mexico tightens its controls.

If that happens, the agency most likely to spot the trend would be the Vienna-based International Narcotics Control Board, which tracks imports and exports of drug chemicals globally. The board's three chemical investigators, sifting through export documents, succeed in halting hundreds of suspicious orders annually.

But the board's power, like its staffing, is limited. With narcotic drugs such as codeine, the agency publishes limits on how much each country should import based on an estimate of medical need. If countries exceed those limits, the board can announce they are violating international law. It has no such authority over pseudoephedrine.

Some U.S. lawmakers and administration officials say it is time for the United States to become more directly involved, in Mexico and beyond.

U.S. Rep. Darlene Hooley, D-Ore., has introduced a bill that would allow DEA officials to inspect sales records of all foreign manufacturers of ephedrine and pseudoephedrine. Companies that refuse would lose the ability to export to the United States. That would enable the DEA to quickly detect a spike in shipments anywhere in the world.

Nick Coleman, counsel to the House Government Reform subcommittee on drug policy, said U.S. officials must work with other countries to scrutinize more intently the flow of pseudoephedrine for legitimate use.

"It's not clear internationally that we are able to track these things," Coleman said, "because at some point, they drop off the radar."

Steve Suo reported this story in Mexico City and Vienna.

Freelance journalist Adrienne Bard contributed to this report in Mexico.

Steve Suo: 503-221-8288; stevesuo@news.oregonian.com

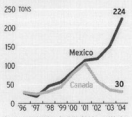
Caption: Color photo by DAVID MAUNG/Special to The Oregonian BW photo by DAVID MAUNG/Special to The Oregonian BW photo by NICK ARROYO/THE ATLANTA JOURNAL-CONSTITUTION BW photo by LUIS MORENO/NOTIMEX BW photo by U.S. DRUG ENFORCEMENT ADMINISTRATION Graphics -- Map by MICHAEL MODE, STEVE SUO/The Oregonian/METH PRODUCTION SURGES IN MEXICO Graphics -- Chart by MICHAEL MODE, STEVE SUO/The Oregonian/ PSEUDOEPHEDRINE IMPORTS SOURCE: CUSTOM DATA Graphics -- Chart by MICHAEL MODE, STEVE SUO/The Oregonian/TOP 10 PSEUDOEPHEDRINE IMPORTERS TO MEXICO, 2004 SOURCE: MEXICAN CUSTOMS DATA VIA MEXICO'S NATIONAL CHAMBER OF THE MANUFACTURING INDUSTRY (CANACINTRA) SEE THE OREGONIAN MICROFILM TO VIEW THE COMPLETE CHARTS and MAPS Graphics -- Sidebar/WHERE TO FIND HELP

Document POR0000020050606e16500025

Return to Headlines

PSEUDOEPHEDRINE IMPORTS

The following are data on pseudoephedrine imports that Canada and Mexico reported to the United Nations.



Source: United Nations Statistics Division and Mexican customs data

Pseudoephedrine imports (TONS)

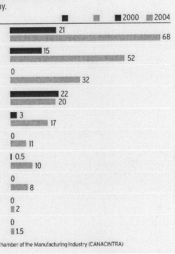
Exporter	2000	2004
India	23	72
China	5	69
Germany	18	61
USA	19	12
Taiwan	5	10
Grand total	**66**	**224**

Source: customs data

MICHAEL MODE/THE OREGONIAN

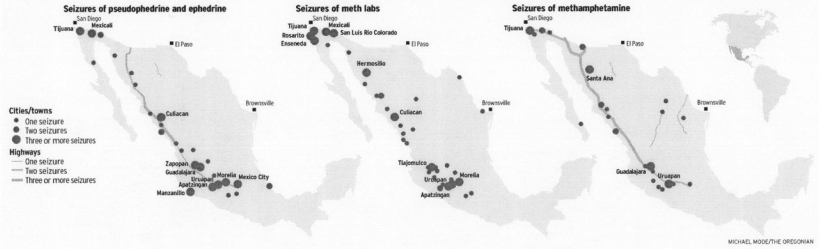
TOP 10 PSEUDOEPHEDRINE IMPORTERS, 2004

Here are imports, in tons, by company.



Source: Mexican customs data via Mexico's National Chamber of the Manufacturing Industry (CANACINTRA)

MICHAEL MODE/THE OREGONIAN



MICHAEL MODE/THE OREGONIAN

ARTICLE ENTITLED "MORE POTENT SUPPLY OF METH WIPES OUT SUCCESS AGAINST HOME LABS," STEVE SUO, SEPTEMBER 25, 2005, *THE OREGONIAN*, SUBMITTED BY THE HONORABLE ROBERT C. SCOTT

Help
Return to Headlines

Local Stories

More potent supply of meth wipes out success against home labs

STEVE SUO
The Oregonian
1,741 words
25 September 2005
The Oregonian
Sunrise
A1
English
© 2005 Oregonian Publishing Company. Provided by ProQuest Information and Learning. All rights reserved.

SUMMARY: Lesson for Congress - Oklahoma sees a steady and ever more potent supply since a 2004 law to curb pseudoephedrine sales

OKLAHOMA CITY -- As members of Congress consider restrictions on the sale of cold pills used to make methamphetamine, they might want to look at what's happened in Oklahoma, which has slashed the number of home meth labs yet failed to curb meth use.

Oklahoma last year became the first state to make consumers visit a pharmacy counter to buy cold medicine containing the meth ingredient pseudoephedrine. Lab seizures plunged from 90 a month in 2003 to nine in June, state officials say. Fires and chemical hazards pose a smaller threat to neighborhoods and children of meth cooks.

But police say a massive influx of meth made by Mexican "superlabs," which can obtain tons of pseudoephedrine in Mexico, has kept meth plentiful and potent. The number of Oklahoma users shows no sign of falling, and property crime still keeps the Oklahoma County Jail at capacity.

"We took away their production," said Tom Cunningham, task force coordinator for the Oklahoma District Attorneys Council. "That didn't do anything for their addiction."

Two decades of government effort have failed to curb the availability of meth. A new analysis of federal data by The Oregonian shows that the drug's potency has hit levels not seen in a decade. Rising purity indicates the supply of meth is growing, and it means a $25 bag of meth will last a user longer.

Congress is weighing competing proposals for how to respond.

The Senate has taken aim at home meth cooks, passing a bill that would impose Oklahoma-style restrictions on the sale of pseudoephedrine nationwide. The House has targeted large-scale Mexican traffickers, taking up a measure that would restrict the sale of pseudoephedrine across the globe.

Federal officials estimate that home labs account for 35 percent of meth consumed in the United States, while Mexican cartels produce 65 percent.

The debate has historic echoes. Lawmakers have previously enacted tighter controls over some sources of meth chemicals while ignoring others here and abroad. Each time, home cooks and international traffickers exploited the loopholes.

Oklahoma's experience shows the potential benefits of limiting access to cold medicine, as the Senate has proposed. Investigators who once spent weeks dismantling labs are now working undercover in hopes of capturing major traffickers.

A rash of similar pseudoephedrine laws in states such as Oregon has led drug companies to sell cold medicines that cannot be converted to meth.

Oklahoma also illustrates the limits of policies that make cold medicine harder to buy in America while leaving it easy for Mexican drug cartels to obtain beyond U.S. borders.

"We have seen a lot of publicity associated with people's access to the ingredients," said Oklahoma County Commissioner Jim Roth. "But from our local government experience, we have not seen a corresponding decline in either the jail population or the social effects that seem to have still lingered from high meth use."

A steady supply

Mexican cartels took little time flooding the Oklahoma meth market after the pseudoephedrine law took effect in April 2004.

"It hit us without much delay," Lt. Charles Smallwood, a drug investigator with the Mayes County Sheriff's Office, said of the arrival of Mexican-made meth. "We started seeing commercial methamphetamine almost immediately."

The Mexican meth sold in Oklahoma is increasingly potent. Drugs seized by federal agents during the first six months of this year averaged 75 percent pure, up from 37 percent two years ago, data from the U.S. Drug Enforcement Administration show.

In the past, sharp increases in purity have prompted comparable jumps in the number of addicts.

But declining local production combined with increasing Mexican imports appear to have canceled each other out in Oklahoma, leaving the supply of the drug stable.

Statistics from the Oklahoma Department of Mental Health and Substance Abuse Services show the number of people entering treatment for meth abuse monthly stopped rising after April 2004. Simultaneously, the

number of cases of forgery -- a crime prosecutors say is commonly committed by meth users -- leveled off in Oklahoma County after a steady rise.

Existing Oklahoma meth users said they saw little change when the state began restricting access to pseudoephedrine products.

Michael Higgins, 22, was in community college and living with his grandmother in Norman when the law took effect last year. His girlfriend had stopped using the drug the year before and moved away with their young daughter.

Higgins, like three other recovering addicts interviewed last month, said he had no trouble buying meth before or after the law took effect. In fact, he began using meth more and more as 2004 progressed. He withdrew from friends and could no longer attend classes without becoming paranoid, fearing classmates knew he was high. He rarely called his daughter.

"My life started going downhill fast," Higgins said. This summer, on the verge of injecting the drug for the first time, he checked into rehab.

Oklahoma County Sheriff John Whetsel said persistent meth use has helped keep his jail filled with 2,850 inmates, the most the fire marshal will allow and 40 percent more than in 2000.

Peter Haddock, an Oklahoma County prosecutor, said he is inundated with forgery cases, and defendants often say meth is why they began printing bogus checks and identification.

"All I know is, I'm getting drug addicts doing this all the time," Haddock said.

New police role

Although meth users are still buying drugs and committing crimes, the decline in local meth labs has dramatically altered the lives of Oklahoma police.

Patrick Vance, an investigator with the drug task force in Shawnee, said taking apart a meth lab can take 12 hours. Filling out the paperwork can consume another 12. In the entire 16 months since the pseudoephedrine law took effect, Vance's agents have worked two or three labs.

"We've got a lot more time to chase the real bad guys," Vance said, "as opposed to the idiots who are cooking it in the backyard."

The shift in emphasis has opened the eyes of veteran drug cops.

"For years, every week we came to work, it was, 'How many labs do we have this week?' " said Kevin McIntire, supervisor for the drug task force in Ardmore. "We're having to refocus on the bigger picture."

McIntire was once skeptical that Mexican traffickers were pumping far more meth into Oklahoma than local cooks. He has become a believer.

"There are hundreds of pounds of methamphetamine moved through small towns all over our area," he said.

"And until recently, we had no idea that these people even existed."

Penetrating Mexican drug cartels is by no means simple, police are finding.

Closing a small-lab case typically meant following a pseudoephedrine thief home from the drugstore. The thief might snitch on his partner for $50 or a plea deal. The network often went no further.

Working a major distribution case means going undercover, winning a wary dealer's trust, then following a chain of connections that can lead all the way to Mexico. It entails months of wiretaps and large-scale purchases.

A single deal could wipe out McIntire's $5,000 annual budget for undercover buys.

Lonnie Wright, director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, said ambitious investigations were exactly what officials hoped to launch after passage of the pseudoephedrine law.

"We're going for those eight, 10 people at the top who are directly connected to the cartel people at the border," Wright said. "We're back to working Mr. Big."

Rising purity nationally

The purity of meth seized by federal agents across the nation has been rising since 1999, The Oregonian's analysis of DEA data has found.

Oklahoma's growing supply of Mexican meth is far from unique.

Meth seized nationally now tests 70 percent to 80 percent pure on average, almost double the level just six years ago. The increase in purity was steady and widespread, from Oregon and California to Texas and Florida.

Law enforcement officials say Mexican traffickers are the reason.

"They're flooding the United States with crystal," said Capt. Craig Durbin of the Oregon State Police.

The trend reflects a near-total reversal in progress made during the 1990s.

In 1995-96 and 1998-99, the government succeeded in producing widespread meth shortages and declines in meth purity by controlling first ephedrine and then pseudoephedrine. The Oregonian revealed in its five-part series, "Unnecessary Epidemic," that meth use declined each time as meth became less potent.

Mexican traffickers have ramped up production since then by acquiring massive quantities of pseudoephedrine, first in Canada and later in Mexico, whose legally approved imports of the chemical have soared in recent years.

Rep. Mark Kennedy, R-Minn., said The Oregonian's new analysis shows that Congress should focus on ending the ability of Mexican traffickers to produce meth.

"We need to have the same energy going after shutting down the importing of meth from Mexico and other countries as we have going after the cold pills," said Kennedy, who wants to withdraw aid to Mexico if it fails to restrain its imports. "In fact, we have to have greater energy because it's a greater source of supply."

The House and Senate appear headed toward conflict over meth.

Kennedy's proposal on aid to Mexico is now part of a broad international meth bill scheduled for a hearing Tuesday in the House Judiciary Subcommittee on Crime. It has no Oklahoma-style limits on sales of cold medicines.

The Senate, meanwhile, has sent the House a bill that would place pseudoephedrine products nationwide behind pharmacy counters. It contains no international provisions.

Sponsors on each side have criticized the other's legislation for failing to address a major source of supply.

With or without new legislation, DEA officials say they are working to confront meth made locally and in Mexico.

"When you have almost 70 percent of what's in the states coming from another country, in this case Mexico, it's a huge concern," said Rusty Payne, a DEA spokesman. "And it's something we're continuing to work with Mexico to address."

Steve Suo: 503-221-8288; stevesuo@news.oregonian.com

Caption: ILLUSTRATION: Charts 4 photos

Document POR0000020051101e19p005ls

Return to Headlines

factiva © 2005 Factiva, Dow Jones & Reuters

LETTER FROM VARIOUS MEDICAL AND PSYCHOLOGICAL RESEARCHERS TO THE SUBCOMMITTEE

July 27, 2005

Contact: David C. Lewis, M.D.
Professor of Community Health and Medicine
Donald G. Millar Distinguished Professor of Alcohol & Addiction Studies
Brown University
Phone: 401-444-1818
E-Mail: David_Lewis@brown.edu

To Whom It May Concern:

As medical and psychological researchers, with many years of experience studying prenatal exposure to psychoactive substances, and as medical researchers, treatment providers and specialists with many years of experience studying addictions and addiction treatment, we are writing to request that policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice.

The use of stigmatizing terms, such as "ice babies" and "meth babies," lack scientific validity and should not be used. Experience with similar labels applied to children exposed parentally to cocaine demonstrates that such labels harm the children to which they are applied, lowering expectations for their academic and life achievements, discouraging investigation into other causes for physical and social problems the child might encounter, and leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives. The suggestion that treatment will not work for people dependant upon methamphetamines, particularly mothers, also lacks any scientific basis.

Despite the lack of a medical or scientific basis for the use of such terms as "ice" and "meth" babies, these pejorative and stigmatizing labels are increasingly being used in the popular media, in a wide variety of contexts across the country. Even when articles themselves acknowledge that the effects of prenatal exposure to methamphetamine are still unknown, headlines across the country are using alarmist and unjustified labels such as "meth babies."

Just a few examples come from both local and national media:

- CBS NATIONAL NEWS, "Generation of Meth Babies" (April 28, 2005) at CBSNews.com
- ARKANSAS NEWS BUREAU, Doug Thompson, "Meth Baby Bill Survives Amendment Vote" (Mar. 5, 2005)
- CHICAGO TRIBUNE, Judith Graham, "Only Future Will Tell Full Damage Speed Wreaks on Kids" ("At birth, meth babies are like 'dishrags'") (Mar. 7, 2004)

- THE LOS ANGELES TIMES, Lance Pugmire, "Meth Baby Murder Trial Winds Up" (Sept.5. 2003 at B3)

- THE SUNDAY OKLAHOMAN, "Meth Babies" (Oklahoma City, OK; May 23, 2004 at 8A)

- APBNEWS.COM, "Meth Infants Called the New "Crack Babies" (June 23, 2000).

Other examples include an article about methamphetamine use in the MINNEAPOLIS STAR TRIBUNE that lists a litany of medical problems allegedly caused by methamphetamine use during pregnancy, using sensationalized language that appears intended to shock and appall rather than inform, "…babies can be born with missing and misplaced body parts. She heard of a meth baby born with an arm growing out of the neck and another who was missing a femur." Sarah McCann, "Meth ravages lives in northern counties" (Nov. 17, 2004 at N1). In May, one Fox News station warned that "meth babies" "could make the crack baby look like a walk in the nursery." Cited in "The Damage Done: Crack Babies Talk Back," Mariah Blake, COLUMBIA JOURNALISM REVIEW Oct/Nov 2004.

Although research on the medical and developmental effects of prenatal methamphetamine exposure is still in its early stages, our experience with almost 20 years of research on the chemically related drug, cocaine, has not identified a recognizable condition, syndrome or disorder that should be termed "crack baby" nor found the degree of harm reported in the media and then used to justify numerous punitive legislative proposals.

The term "meth addicted baby" is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be "addicted" to methamphetamines or anything else. The news media continues to ignore this fact.

- A CNN report was aired repeatedly over the span of a month, showing a picture of a baby who had allegedly been exposed to methamphetamines prenatally and stating: "This is what a meth baby looks like, premature, hooked on meth and suffering the pangs of withdrawal. They don't want to eat or sleep and the simplest things cause great pain." CNN, "The Methamphetamine Epidemic in the United States," Randi Kaye. (Aired Feb. 3, 2005 – Mar. 10 2005).

- One local National Public Radio station claims that "In one Minnesota County, there is a baby born addicted to meth each week." (Found at http://news.minnesota.publicradio.org/features/2004/06/14_hetlande_methfostercare/ from June 14, 2004).

In utero physiologic dependence on opiates (not addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosable and treatable, but no such symptoms have been found to occur following prenatal cocaine or methamphetamine exposure.

Similarly, claims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and re-incarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests the need to improve and expand treatment offered to methamphetamine users.

Too often, media and policymakers rely on people who lack any scientific experience or expertise for their information about the effects of prenatal exposure to methamphetamine and about the efficacy of treatment. For example, a NEW YORK TIMES story about methamphetamine labs and children relies on a law enforcement official rather than a medical expert to describe the effects of methamphetamine exposure on children. A police captain is quoted stating: "Meth makes crack look like child's play, both in terms of what it does to the body and how hard it is to get off." (Fox Butterfield, Home Drug-Making Laboratories Expose Children to Toxic Fallout, Feb 23, 2004 A1)

We are deeply disappointed that American and international media as well as some policy makers continue to use stigmatizing terms and unfounded assumptions that not only lack any scientific basis but also endanger and disenfranchise the children to whom these labels and claims are applied. Similarly, we are concerned that policies based on false assumptions will result in punitive civil and child welfare interventions that are harmful to women, children and families rather than in the ongoing research and improvement and provision of treatment services that are so clearly needed.

We would be happy to furnish additional information if requested or to send representatives to meet with policy advisors, staff or editorial boards to provide more detailed technical information. Please feel free to contact David C. Lewis, M.D., 401-444-1818, David_Lewis@brown.edu, Professor of Community Health and Medicine, Brown University, who has agreed to coordinate such requests on our behalf and who can provide you with contact information for the experts listed below in alphabetical order.

1. Lily Alvarez, Kern County Mental Health Behavioral Health System Administrator, Kern County Mental Health Department, Bakersfield, CA
2. M. Douglas Anglin, Ph.D., Professor in Residence, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
3. Robert E. Arendt, Ph.D., Associate Professor of Pediatrics, Ohio State University, Grove City, OH
4. Robert L. Balster, Ph.D., Butler Professor of Pharmacology and Toxicology; Director, Institute for Drug and Alcohol Studies, Virginia Commonwealth University, Richmond, VA
5. Marjorie Beeghly, Ph.D., Assistant Professor of Pediatrics, Harvard Medical School & Senior Research Associate, Children's Hospital- Boston, Child Development Unit, Boston, MA
6. Marylou Behnke, M.D., Professor, Department of Pediatrics, University of Florida, College of Medicine, Gainesville, FL

7. Adam Bisaga, M.D., Research Psychiatrist, Columbia University & Addiction Psychiatrist, New York State Psychiatric Institute, New York, NY
8. Maureen Black, Ph.D., Professor, Department of Pediatrics, University of Maryland Hospital for Children, Baltimore, MD
9. Susan Blacksher, Executive Director, California Association of Addiction Recovery Resources, Sacramento, CA
10. Elizabeth R. Brown, M.D., Director of Neonatology & Associate Professor of Pediatrics, Boston University School of Medicine & Boston Medical Center, Boston, MA
11. Theresa L. Cannon, Executive Vice President, Behavioral Health Services, Inc., Gardena, CA
12. Wendy Chavkin, M.D., M.P.H., Professor of Clinical Public Health and Obstetrics and Gynecology, Mailman School of Public Health & College of Physicians and Surgeons, Columbia University, New York, NY
13. Claire D. Coles, Ph.D., Professor, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine & Director, Fetal Alcohol Center, Marcus Institute, a Division of the Kennedy Krieger Institute at Emory University, Atlanta, GA
14. Jay Davidson, L.C.S.W., C.A.D.C., President and CEO, The Healing Place, Louisville, KY
15. Nancy Day, Ph.D., Professor of Psychiatry and Epidemiology, University of Pittsburgh School of Medicine, Pittsburgh, PA
16. Eric Denner, Licensed Marriage and Family Therapist, San Francisco General Hospital Trauma Recovery Center, San Francisco, CA
17. Chris Derauf, M.D., Associate Professor of Pediatrics, University of Hawaii School of Medicine, Honolulu, HI
18. Christine Dickinson, Chemical Dependency Specialist and Proposition 36 Coordinator, Tarzana Treatment Centers, Northridge, CA
19. Fonda Davis Eyler, Ph.D., Professor of Pediatrics, University of Florida Health Science Center, Gainesville, Fl
20. Jennifer Feiock, Program Director, Alcohol Drug Council, High Gain Project, Santa Monica, CA
21. Gabriele Fischer, Ph.D., Professor, Medical University of Vienna, Department of Psychiatry, Drug Addiction Clinic, Vienna, Austria
22. Deborah A. Frank, M.D., Professor of Pediatrics, Boston University, School of Medicine, Boston, MA
23. Peter Fried, Ph.D., Professor, Department of Psychology, Carleton University, Ottawa, Ontario, Canada
24. Judith M. Gardner, Ph.D., High Risk Infant Development Follow-up Program, New York State Institute for Basic Research in Developmental Disabilities, New York, NY
25. Jim Gilmore, Director of Residential/Outpatient Services, Behavioral Health Services, Inc., Gardena, CA
26. Penny Grant, M.D., Associate Professor of Pediatrics, University of Oklahoma Health Sciences Center, Tulsa, OK
27. John Timothy Gray, M.A., Alcohol and Drug Corrections Specialist, Communicare, Inc., Elizabethtown, KY
28. Christine Grella, Ph.D., Research Psychologist, UCLA Integrated Substance Abuse Programs, Los Angeles, CA

29. Irina Gromov, M.D., Ph.D., Medical Director, Matrix Alliance Recovery Systems, Dallas, TX
30. John H. Hannigan, Ph.D., Professor of Obstetrics, Psychology and Cellular and Clinical Neurobiology, Wayne State University, C.S. Mott Center for Human Growth and Development, Detroit, MI
31. Wm. Frees Haning, III, M.D., FASAM, Director of Addiction Psychiatry/Addiction Medicine Program & Associate Dean for Graduate Affairs, University of Hawaii, John A. Burns School of Medicine, Honolulu, HI
32. Nancy Haug, Ph.D., Assistant Professor, San Francisco General Hospital, San Francisco, CA
33. Lance R. Heffer, Psy.D., Mental Health Director, Special Programs, Communicare, Inc., Elizabethtown, KY
34. Brandon Hurley, M.P.H., Prevention Specialist, Bluegrass Prevention Center, Lexington, KY
35. Hallam Hurt, M.D., Associate Professor of Pediatrics, Neonatology, Department of Pediatrics, University of Pennsylvania School of Medicine, Children's Hospital of Philadelphia, Philadelphia, PA
36. Joseph L. Jacobson, Ph.D., Professor, Department of Psychiatry and Behavioral Neurosciences, Wayne State University, School of Medicine, Detroit, MI
37. Sandra W. Jacobson, Ph.D., Professor, Department of Psychiatry and Behavioral Neurosciences, Wayne State University, School of Medicine, Detroit, MI
38. Karol Kaltenbach, Ph.D., Director, Maternal Addiction Treatment Education and Research, Jefferson Medical College, Thomas Jefferson University, Philadelphia, PA
39. Jonathan Kamien, Ph.D., Research Scientist, Friends Research Institute, Los Angeles, CA
40. Stephen R. Kandall, M.D., F.A.A.P., Professor of Pediatrics, Emeritus, Albert Einstein College of Medicine, Raleigh, NC
41. Bernard Z. Karmel, Ph.D., Infant Development, New York State Institute for Basic Research in Developmental Disabilities, New York, NY
42. Elizabeth C. Katz, Ph.D., Research Scientist, Friends Social Research Center, Baltimore, MD
43. Dennis Kenmore, Program Coordinator & Instructor, Alcohol Drug Council, Santa Monica, CA
44. Jane A. Kennedy, D.O., Associate Clinical Professor of Psychiatry, University of Colorado Medical School, Denver, CO
45. John R. Knight, M.D., Associate Professor of Pediatrics, Harvard Medical School & Director, Center for Adolescent Substance Abuse Research, Children's Hospital, Boston, MA
46. Gideon Koren, M.D., F.R.C.P.C., Professor of Pediatrics, Pharmacology, Pharmacy, Medicine, and Medical Genetics, University of Toronto; Senior Scientist, The Hospital for Sick Children, Clinical Pharmacology Department; Director, Motherisk Program, The Ivey Chair in Molecular Toxicology, University of Western Ontario, Canada
47. Thomas Kosten, M.D., Professor of Psychiatry and Medicine, Yale School of Medicine, West Haven, CT
48. Donald J. Kurth, M.D., FASAM, President, California Society of Addiction Medicine, Alta Loma, CA

49. Linda LaGasse, Ph.D., Assistant Professor of Pediatrics, Brown University, Providence, RI
50. Barry Lester, Ph.D., Professor of Psychiatry and Pediatrics, Brown Medical School, Director, Infant Development Center, Providence, RI
51. Joreen Long, Deputy Director, Alcohol Drug Council, High Gain Project, Santa Monica, CA
52. Paul R. Marques, Ph.D., Senior Research Scientist, Pacific Institute for Research and Evaluation, Calverton, MD
53. Jane C. Maxwell, Ph.D., Research Professor, The University of Texas at Austin, Austin, TX
54. Linda Mayes, M.D., Arnold Gesell Professor, Child Psychiatry, Pediatrics, and Psychology, Yale Child Study Center, Yale University School of Medicine, New Haven, CT
55. Nena Messina, Ph.D., Associate Research Criminologist, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
56. Jan Moffitt, Executive Director, Central Texas Council on Alcoholism and Drug Abuse, Harker Heights, TX
57. Connie E. Morrow, Ph.D., Research Associate Professor and Licensed Psychologist,Associate Director, Perinatal CARE Program, Department of Pediatrics, University of Miami, Coral Gables, FL
58. Debra A. Murphy, Ph.D., Research Psychologist, UCLA Department of Psychiatry, Los Angeles, CA
59. Michael A. Nader, Ph.D., Professor of Pharmacology, Wake Forest University, Winston-Salem, NC
60. Prasanna Nair, M.D., M.P.H., Professor of Pediatrics, University of Maryland School of Medicine, Baltimore, MD
61. Daniel R. Neuspiel, M.D., M.P.H., Associate Chairman of Pediatrics, Beth Israel Medical Center, New York, NY
62. Robert G. Newman, M.D., Director, The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center, New York, NY
63. Noosha Niv, Ph.D., Post-Doctoral Fellow, National Institute on Drug Abuse, Los Angeles, CA
64. Judith Novgrod, Psy.D., Therapist, Matrix Institute of Addictions, Los Angeles, CA
65. Steven J. Ondersma, Ph.D., L.P. Assistant Professor, Wayne State University, Detroit, MI
66. Monica S. Paz, Research Associate Psychometrist, Los Angeles Biomedical Research Institute, Torrance, CA
67. Michael L. Prendergast, Ph.D., Director, Criminal Justice Research Group, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
68. Barbara E. Ramlow, MA, Director, University of Kentucky Institute on Women and Substance Abuse, Center on Drug and Alcohol Research, Lexington, KY
69. Richard Rawson, Ph.D., Associate Director, UCLA Integrated Substance Abuse Programs, Neuropsychiatric Institute and Hospital, Los Angeles, CA
70. Laurence Re, HIV Prevention Counselor, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
71. Cathy J. Reback, Ph.D., Director, Van Ness Recovery House, West Hollywood, CA

72. Gale A. Richardson, Ph.D., Associate Professor of Psychiatry and Epidemiology, University of Pittsburgh School of Medicine, Pittsburgh, PA
73. John D. Roache, Ph.D., Professor of Psychiatry, Chief of Alcohol and Drug Addiction Division, University of Texas Health Science Center at San Antonio, San Antonio, TX
74. Carrie Roberson, M.S. Instructor/ Director of Child Development Center, Butte College, Oroville, CA
75. Lucinda Sabo, Clinical Research Associate, Los Angeles Biomedical Research Institute, Torrance, CA
76. Jeffrey Samet, M.D., M.A., M.P.H., Professor of Medicine and Social and Behavioral Sciences, Boston Medical Center, Boston University School of Medicine and Public Health, Boston, MA
77. Sidney Schnoll, M.D., Ph.D., Clinical Professor of Internal Medicine and Psychiatry, Medical College of Virginia, Westport, CT
78. Garnet Sexton, B.S., C.A.D.C., University of Kentucky, Targeted Assessment Specialist, Hazard, KY
79. Cheryl Powell Shook, M.S., C.A.D.C., Program Coordinator, Bridges Substance Abuse Recovery Program, Elizabethtown, KY
80. Sara Simon, Ph.D., Associate Research Psychologist, UCLA Neuropsychiatric Institute, Los Angeles, CA
81. Lynn T. Singer, Ph.D., Professor of Pediatrics, Case Western Reserve University, Cleveland, OH
82. Lynne M. Smith, M.D., Associate Professor of Pediatrics, David Geffen School of Medicine at UCLA, Torrance, CA
83. Carol Stange, Prevention Services Coordinator, Prevention Research Institute, Lexington, KY
84. Catherine Stanger, Ph.D., Research Associate Professor of Psychiatry, University of Vermont, South Burlington, VT
85. Matthew A. Torrington, M.D., Clinical Research Physician and Addiction Medicine Specialist, Matrix Institute, West Los Angeles, CA
86. Anita Vermund, Ph.D., Service Chief II, County of Orange Health Care Agency, Orange, CA
87. Kristin Wheelan, CADC II, Substance Abuse Specialist, County of Kern, Mental Health Department, Bakersfield, CA
88. Jayne Wise, Executive Director, Alcohol Drug Council, High Gain Project, Santa Monica, CA
89. George Woody, M.D., Professor, Department of Psychiatry, University of Pennsylvania & Clinical Trials Network, Treatment Research Institute, Philadelphia, PA
90. Trecia Wouldes, Ph.D., Lecturer, University of Auckland, Faculty of Medical & Health Sciences, Auckland, New Zealand
91. Kay H. Yanit, R.N., M.C.C., Maternity Case Manager, McKenzie Willamette Medical Center, Women's Health and Birth Center, Eugene, OR
92. Nancy K. Young, Ph.D., Executive Director, Children and Family Futures, Irvine, CA

ADDITINOAL PREPARED STATEMENT OF DR. BARRY M. LESTER, PROFESSOR OF PSYCHIATRY & HUMAN BEHAVIOR AND PEDIATRICS, BROWN UNIVERSITY MEDICAL SCHOOL

Chairman Coble, Chairman Sensenbrenner, Ranking Member Scott, Members of the Subcommittee, thank you for the opportunity to testify on H.R. 3889, the Methamphetamine Epidemic Elimination Act.

We are in a similar situation today with methamphetamine as we were 20 years ago during the cocaine epidemic. During that time, there was legitimate concern for the welfare of children exposed to cocaine in the womb. But based on insufficient and inaccurate information, society rushed to judgment—an over-reaction that had negative consequences for women and children (1). Many women were prosecuted and children were removed from their birth mothers. Families split up. As a result, by the mid 1990s, the number of children in foster care reached an all-time high of over 500,000. Many of these children suffered emotional problems from multiple foster care placements. This lead to the 1997 passage of the Adoption and Safe Families Act, or ASFA, requiring permanent placement of a child within 12 months of being removed from his or her birth mother. Unfortunately, ASFA has been counterproductive for families who could easily be reunited if they had access to appropriate drug treatment and/or if they were not in jail for drug related offenses.

After 20 years of research, we learned that the effects of cocaine are not nearly as severe as initially feared (2). In fact, when factors like other drugs and poverty are controlled, the effects are subtle—IQ lowered by 3 to 4 points, a slight increase in behavior or attention problems. These effects are similar to those caused by cigarette smoking during pregnancy. Scientists also learned that while there are most definitely drug users who are inadequate mothers, there are also drug users who are competent mothers who, with treatment, can care for their children. Families can be preserved.

We also learned that the "cure" of foster care can be worse than the disease of addiction. University of Florida researchers (3) studied two groups of infants born with cocaine in their systems. One group was placed in foster care, the other with birth mothers able to care for them. After six months, the babies were tested using all the usual measures of infant development: rolling over, sitting up, reaching out. Consistently, the children placed with their birth mothers did better. For the foster children, being taken from their mothers was more toxic than the cocaine.

It is extremely difficult to take a swing at "bad mothers" without the blow landing on their children. That doesn't mean we can simply leave children with addicts—it does mean that drug treatment for the parent is almost always a better first choice than foster care for the child.

Our understanding of addiction has also changed in two decades. We know more about addiction as a disease—a medical condition that can be treated. Addiction is a complex disease with multiple mental health co-morbidities; Women who use drugs also tend to be depressed and anxious and may have even more severe mental health problems. So the bad news: Addiction is complex. The good news: Addiction is treatable. We can reduce the problem of drug addiction in this country. I don't see treatment addressed in this legislation.

We learned some hard lessons since the cocaine story unfolded. I am concerned that we are on the verge of making the same mistakes with methamphetamine that we made with cocaine, as suggested by sensational media coverage, the absence of federal treatment dollars—and the punitive nature of this bill.

Methamphetamine is a stimulant like cocaine and produces similar effects on neurotransmitters in the brain. Research on the effects of prenatal methamphetamine exposure on child outcome is just beginning (4). The National Toxicology Program, U.S. Department of Health and Human Services, Center for the Evaluation of Risks to Human Reproduction (CERHR), Expert Panel Report of 2005 on meth concluded that

> in terms of the potential adverse reproductive and developmental effects of meth exposure, that "studies that focused upon humans were uninterpretable due to such factors as a lack of control of potential confounding factors and the issue of the purity and contaminants of the methamphetamine used by the drug abusers.

To my knowledge, my current research into the prenatal effects of methamphetamine is the only such project funded by the National Institutes of Health (NIDA). Children in our study are still infants. So we can't measure all the effects of this drug. But, so far, we are seeing the same kind of subtle changes with methamphetamine that we saw with cocaine (5). Again—to put this in context—not very different than what you'd see with cigarette smoking.

In a recent open letter (attached), more than 90 medical and psychological researchers, with many years of experience studying prenatal exposure to psychoactive substances, outlined the science in this area.

> The use of stigmatizing terms, such as "ice babies" and "meth babies," lack scientific validity and should not be used. Experience with similar labels applied to children exposed parentally to cocaine demonstrates that such labels harm the children to which they are applied, lowering expectations for their academic and life achievements, discouraging investigation into other causes for physical and social problems the child might encounter, and leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives. The suggestion that treatment will not work for people dependant upon methamphetamines, particularly mothers, also lacks any scientific basis.

Does this mean that methamphetamine is harmless? Is it acceptable for women to use meth during pregnancy? Of course not. And we know from previous research—including research with cocaine-using mothers—that even small neurobehavioral effects can turn to larger deficits if the parenting environment is not adequate. And, it is also possible that there are drug effects that don't show up until children get to school and higher-level brain functions get activated.

In terms of treatment, even a cursory examination of the data shows that methamphetamine is not uniquely addictive, and that methamphetamine abuse is treatable. The federal government's most recent National Survey on Drug Use and Health found that 4.9% of Americans have used methamphetamine at some point in their life. Only .6%, however, have used it within the last year, and only .2% have used it within the last month. Most people who use methamphetamine do not become addicted and those who do become addicted can be treated. The recent open letter by dozens of leading researchers notes:

> claims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and reincarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests the need to improve and expand treatment offered to methamphetamine users.

Disturbingly, this bill would lower the trigger thresholds for long mandatory minimum sentences to amounts that methamphetamine addicts typically possess. It seems designed to ensure that Americans with substance abuse problems get long prison sentences instead of treatment. What we need is a balanced approach—one that will attack the root causes of drug addiction. Sending more people to prison for longer periods of time is not the answer. We know enough now to fight addiction with treatment and do much more to keep many families safely together.

Here are some specific suggestions:

- Develop a national consensus on how to deal with maternal drug use that draws on current research and tested treatment strategies—and demonstrates a fair and unbiased attitude towards drug-addicted women and their children.
- Urge states to enact legislation protecting mothers who voluntarily seek drug treatment from having their children taken away. Many mothers who want treatment are afraid to come forward out of fear they will lose their children.
- Improve access to treatment and develop coordinated treatment programs with interconnected services based on the needs of women, mothers and children. Models of methamphetamine treatment are based on adult male models. Few are designed to meet the specific needs of women, pregnant women or mothers. For example, we know from the cocaine experience that it does no good to tell a poor mother with four kids in tow that she has six different appointments in six different locations without providing transportation or baby-sitting.
- Enact a federal grant program that encourages states to develop treatment programs for women.and families
- Develop systemic prevention efforts. This includes education to prevent onset or continuation of drug use as well as treatment to prevent future problems due to drug use.
- Develop Family Treatment Drug Courts with the goal of keeping custody or reunification whenever possible. Drug Courts are a way providing a "treatment with teeth" approach that includes rewards for compliance with treat-

ment and sanctions for noncompliance with treatment. In Rhode Island, we have a program called VIP (Vulnerable Infants Program) which includes a Family Treatment Drug Court (FTDC). Vulnerable is meant to imply that these children are somewhat fragile but not damaged and of course they are Very Important People. This is a voluntary "treatment with teeth" program that has been successful. We have reduced the length of stay of drug-exposed babies in the hospital, increased the number of infants who are going home with their biological mothers (hence reducing the number in foster care) and increased the number of children being reunified with their birth mothers. We should consider waiving punishment for clients who agree to and comply with treatment.

Sacramento County, California has pulled all of these strategies together into a comprehensive, effective system for coping with meth addiction and keeping families safely together. As a program planner for child protective services in that county recently told the authoritative trade journal Youth Today:

> We've got big meth issues in Sacramento County, but they're not paralyzing anybody.

- Enact legislation prohibiting health facilities that receive federal funds from denying treatment to patients with addition and dependency disorders because they have relapsed and manifested the disease they are fighting. Many people with diabetes cheat—use sugar, fail to stay on their diets yet they are not denied insulin, thrown out of their treatment program, and disconnected from the health care that can eventually help them to control their disease. Similarly people with hypertension who eat fatty foods and fail to exercise are not thrown out of their treatment programs and do not have their blood pressure medication taken away from them. Congress could significantly improve health care and chances for long-term recovery by ending this unique form of discrimination.

Mr. Chairman, I recognize that the focus of H.R. 3889 is to "further regulate and punish illicit conduct relating to methamphetamine" and that other companion bills may address the treatment and other research issues raised in my testimony. However, I would ask that the official hearing record include a copy of the Final Report of the Methamphetamine Interagency Task Force *http://www.ojp.usdoj.gov/nij/methintf/* as an existing comprehensive strategy aimed at blending both criminal justice and public health approaches to reducing methamphetamine use. While this Report originated in a previous Administration, most if not all of the guiding principles, findings, recommendations, and research priorities are still relevant and may save Congress and the current Administration from reinventing the wheel.

Specifically, I'm sure that the scientific community would endorse the panoply of prevention, education and treatment initiatives outlined in the report. I would give special emphasis to the following: (1) Increasing treatment capacities in correctional facilities; (2) conducting research on which treatment models work best in prison, in drug court and in the community; (3) increasing research on medications development and other treatments for meth, and (4) conducting research on the effects of meth on pregnant women, treatment of exposed infants and (5) evaluation of treatment programs for children and adolescents.

Additionally, I would appreciate it if you would include the attached update highlighting NIDA research on methamphetamine addiction.

In sum, we have made tremendous strides in 20 years when it comes to understanding drug addiction and treatment. We have the opportunity to keep families together today in ways that were not possible only a few years ago. I am very optimistic about our ability to reduce addiction and save future generations of children through treatment. It would be not only a missed opportunity, but a major step backward, to put all of our eggs in the punishment basket.

Mr. Chairman, thank you again for the opportunity to testify here today. I would be happy to answer any questions.

REFERENCES

1. Lester, B.M., Andreozzi, L., Appiah, L. Substance Use During Pregnancy: Time For Policy To Catch up With Research. *Harm Reduction Journal,* 2004 Apr 20;1(1):5.

2. Lester, B. M., LaGasse, L. L., and Seifer, R. Cocaine exposure and children: The meaning of subtle effects. *Science.* 1998;282:633–634

3. Wobie, K., Behnke, M., et. al., To Have and To Hold: A Descriptive Study of Custody Status Following Prenatal Exposure to Cocaine, paper presented at joint an-

nual meeting of the American Pediatric Society and the Society for Pediatric Research, May 3, 1998.

4. Wouldes, T., LaGasse, L., Sheridan, J., Lester, B. Maternal Methamphetamine Use During Pregnancy and Child Outcome: What Do We Know? *N Z Med J. Nov 26;117(1206):U1180, 2004.*

5. Lester, B., LaGasse, L, Smith, L. M., Derauf, C., Grant, P., Shah, R., Arria, A., Huestis, M., ann Liu, J. Prenatal exposure to methamphetamine and child development. *Proceedings of the Community Epidemiology Work Group.* 2005;22:1–4

ATTACHMENT

Methamphetamine Addiction: Cause for Concern – Hope for the Future

Research Update from the National Institute on Drug Abuse

Methamphetamine abuse is a significant problem in the United States

- Over 12 million people 12 years and older have abused methamphetamine in their lifetime and over 600,000 were current users in 2004 (NSDUH).
- Abuse appears to be increasing in certain areas of the country, especially rural communities.
- According to NIDA's 2004 Monitoring the Future Survey, there are significant decreases in methamphetamine abuse among eighth graders, and the abuse among 10th and 12th graders appears to have stabilized (Figure 1).
- Methamphetamine abuse is dangerous due to its high addiction liability and significant health and social consequences.

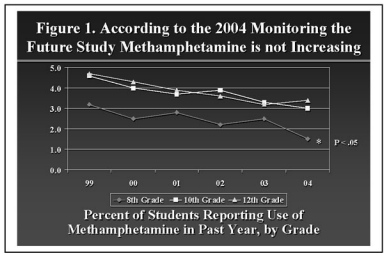


Figure 1. According to the 2004 Monitoring the Future Study Methamphetamine is not Increasing

Percent of Students Reporting Use of Methamphetamine in Past Year, by Grade

Methamphetamine acts by increasing the release of dopamine in the brain, which leads to euphoria. However, this extra sense of pleasure is followed by a "crash" that often leads to increased use of the drug and eventually to difficulty in feeling any pleasure. Long-term methamphetamine abuse also results in many damaging physical and psychiatric effects, such as:

- Addiction;
- Violent Behavior;
- Anxiety;
- Confusion;
- Insomnia;
- Psychotic features (e.g. paranoia, hallucinations, delusions); and
- Cardiovascular problems (e.g. rapid heart rate, irregular heartbeat, increased blood pressure, stroke).

What Does Methamphetamine Do to the Brain?

Methamphetamine's adverse effects on the brain are clear. In animals, methamphetamine damages nerve terminals in dopamine- and serotonin-containing regions of the brain. Similarly, in humans, methamphetamine alters the brain in ways that impair decision-making, memory, and motor behaviors, and causes structural and functional deficits in brain areas associated with depression and anxiety. Dopamine cell death, however, has not been documented in methamphetamine abusers, which could explain why with extended abstinence, there is some recovery from methamphetamine-induced changes in dopamine function (Figure 2).

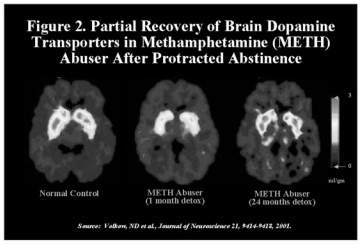


Figure 2. Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence

A recent neuroimaging study of methamphetamine abusers showed partial recovery of brain function in some regions following protracted abstinence, associated with improved performance on motor and verbal memory tests. However, function in other regions did not display recovery even after two years of abstinence, indicating that some of these changes can be very long lasting.

Methamphetamine and HIV

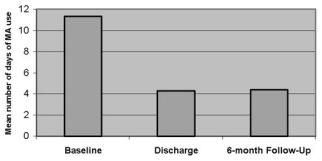
In addition to its damaging effects on the brain, methamphetamine is inextricably linked with HIV, hepatitis C, and other sexually transmitted diseases. Its abuse increases the risk of contracting HIV not only due to the use of contaminated injection equipment, but also due to increased risky sexual behaviors as well as physiological changes that may favor HIV transmission.

Methamphetamine abuse may also affect HIV disease progression. For example, clinical studies suggest that current methamphetamine abusers on highly active antiretroviral therapy may be at greater risk of developing AIDS than non-users, possibly due to poor medication adherence or interactions between methamphetamine and HIV medications. Similarly, preliminary studies suggest that interactions between methamphetamine and HIV itself may lead to more severe consequences for methamphetamine-abusing, HIV-positive patients, including greater brain damage and cognitive impairment. More research is needed to better understand these interactions.

Treatments for Methamphetamine Addiction

Methamphetamine addiction can be successfully treated. The Matrix Model, a proven effective treatment for methamphetamine addiction, consists of a 16-week intervention that includes intensive group and individual therapy to promote the behavioral changes needed to remain off drugs, prevent relapse, and establish a new lifestyle unrelated to drugs. When applied to methamphetamine abusers, the Matrix Model has been shown to significantly reduce drug use (Figure 3).

Figure 3. Efficacy of the Matrix Model



Source: Rawson et al. (2004) Addiction 99:708-17.

Motivational Incentives for Enhancing Drug Abuse Recovery (MIEDAR), an incentive-based method for cocaine and methamphetamine abstinence, is another treatment program that has recently been tested in methamphetamine abusers through NIDA's National Drug Abuse Clinical Trials Network, and also shows promise.

NIDA is also developing medications for methamphetamine addiction. In 2000, NIDA established the Methamphetamine Clinical Trials Group (MCTG) to conduct clinical (human) trials of medications for methamphetamine addiction in geographic areas in which its abuse is particularly high, including San Diego, Kansas City, Des Moines, Costa Mesa, San Antonio, Los Angeles, and Honolulu. For example, modafinil, which is used to treat narcolepsy, has shown promise in cocaine treatment and may have positive effects on executive function and impulsivity, will be tested in the MCTG. Another potential treatment is the anti-epileptic medication, gamma-vinyl GABA (GVG). Studies have demonstrated that half of the GVG-treated methamphetamine addicts remained drug free for approximately six weeks despite living in their normal home environment with ready access to drugs.

To treat methamphetamine overdose, NIDA is also developing monoclonal antibodies to methamphetamine that will sequester the drug in the bloodstream thereby preventing its deleterious effects.

For further information please visit NIDA on the web at www.drugabuse.gov or contact:

Geoffrey Laredo
Senior Advisor to the Director
Office of Science Policy and Communications
National Institute on Drug Abuse
301-594-6852
fax 301-443-6277
glaredo@nida.nih.gov