

EVALUATING THE SYNTHETIC DRUG CONTROL STRATEGY

HEARING

BEFORE THE
SUBCOMMITTEE ON CRIMINAL JUSTICE,
DRUG POLICY, AND HUMAN RESOURCES
OF THE

COMMITTEE ON
GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES
ONE HUNDRED NINTH CONGRESS

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EVALUATING THE SYNTHETIC DRUG CONTROL STRATEGY

FRIDAY, JUNE 16, 2006

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 2247, Rayburn House Office Building, Hon. Mark E. Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder, Cummings, Watson, and Norton.

Staff present: J. Marc Wheat, staff director and chief counsel; Dennis Kolcoyne, counsel; Malia Holst, clerk; Tony Haywood, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. SOUDER. The subcommittee will come to order. Good morning, and I thank you all for coming. We have been looking forward for some time now to the release of the synthetic drug control strategy which was finally unveiled on June 1st. Today we will hear from several witnesses as to the strengths and weaknesses of this plan.

With the near universal recognition that methamphetamine addiction has become an epidemic, it is imperative that the Federal Government provide the best possible leadership and vision on this pressing social and law enforcement problem. State and local governments, as well as many private agencies devoted to helping families and communities cope with this scourge have long complained that, no matter how diligent non-Federal actors have been or could be, nothing can fill the void of national direction. Only Federal leadership will suffice, and many have awaited the new strategy with guarded-only optimism.

There seem to be ample reason for concern as to the administration's commitment to amass strategy. We can hardly forget a key presentation at the HHS-sponsored conference in Utah last August 19th, which said, "We don't need a war on methamphetamine." Nor can we forget, as the New York Times reported on December 15th, that FDA was working behind the scenes to block the Combat Meth Act.

This strategy sets three primary goals: One, a 15 percent reduction in methamphetamine abuse; two, a 15 percent reduction in prescription drug abuse; and three, a 25 percent reduction in domestic methamphetamine laboratories.

The strategy itself concedes that the first two goals may be met without much change in the Federal response given that recent trends already may be moving in that direction. The third goal is likely to be achieved due to tough restrictions on precursor chemicals set out first by most of the States and now by Congress to the Combat Methamphetamine Epidemic Act enacted this spring with virtually no support, and even some opposition from the administration.

With the national standard for precursor chemical control soon to be in full effect through the Combat Methamphetamine Epidemic Act, hopes are high for significant declines in domestic meth production, but meth will remain readily available, unless international diversion of precursor chemicals can be stopped. This is borne out by the increased smuggling of meth across the southwest border, as Mexican drug traffickers move to exploit the decline in domestic meth production.

Accordingly, the strategy begins with this international aspect, laying out three prongs. One, attaining better information about international trade in pseudoephedrine; two, swift and effective implementation of the Combat Meth Act; and, three, continued law enforcement and border activities and continued partnership with Mexico.

Regarding the first prong, the administration has been taking some positive steps and recognizes that the problem cannot be tackled until its international nature and scope is fully understood. The challenge begins with this hopeful fact: The main precursor chemical pseudoephedrine, PSE, is produced in a handful of countries, chiefly in China, India, and Germany. If exportation of PSE can be tracked and controlled from its sources, we could go a long way in choking off the essential ingredient needed by criminal organizations now profiting by producing meth chiefly in Mexico and distributing it throughout this country. Fortunately, the administration has been making diplomatic efforts through the U.N. Commission on Narcotic Drugs to persuade some reluctant governments that the meth epidemic is global, and that they should get with the program.

Though the implementation of the Combat Meth Act is the second prong of the international meth strategy, the strategy restates provisions of the law while not always describing how ONDCP will ensure that implementation will be carried out by responsible agencies.

The third prong of the international segment of the strategy, that of law enforcement at the border and partnership with Mexico, summarizes current bilateral law enforcement efforts within Mexico. Efforts to train Mexican law enforcement and significantly upgrade its quality are extensive. Mexico has also moved aggressively to curtail illegal diversion of meth precursors, and in some respects, it is ahead of the United States in this area.

Although the strategy states that its intent is to strengthen border protection, it disturbingly fails to elaborate on this at all and is completely silent on what will be done in this area. In fact, the strategy makes no mention of the Department of Homeland Security, which contains multiple agencies tasked with border security and counterdrug activities.

This is almost shocking, considering that it now seems universally accepted within the administration that approximately 80 percent of the meth being consumed in this country is coming from Mexico. Stopping meth smuggling from Mexico is clearly imperative, and yet the strategy fails to explain why border protection is adequate or just how such protection will be strengthened.

The domestic aspect of the strategy leans heavily on the requirement of working closely with State and local officials. The strategy acknowledges that the overwhelming majority of drug arrests and prosecutions, over 90 percent, are conducted by State and local authorities. Nonetheless, we have been told by people we trust that there wasn't much consultation or dialog with State and local officials in crafting this strategy. And while it touts the efforts of State and local authorities, the administration seeks to drastically cut the Federal programs which have been essential to State and local law enforcement.

For example, the administration wants Congress to eliminate the Byrne Justice Assistance Grants Program, JAG. In 2004, one third of all the meth labs seized were taken down by JAG-funded State and local drug task forces. The strategy fails to explain how the State and local authorities can be expected to keep up this pace of lab seizures if the administration succeeds in gutting the very programs that make it possible. Why would you hold a press conference about a strategy based on programs you are proposing to eliminate?

The administration has asserted that prevention is one of the three pillars of its anti-drug efforts. Yet, declining funding in this area, only at 11.7 percent of the drug control budget, casts doubt on this claim. And the strategy is thin on prevention, with only a brief reference to research under way at the National Institute on Drug Abuse, NIDA, and almost as brief a discussion of the National Youth Antidrug Media Campaign. The discussion ends by noting the importance of voluntarily airing the ads by local radio and TV stations, yet it says nothing about how such voluntary airing will be encouraged.

One of the most appalling aspects of meth is its grisly aftermath. This includes children who are poisoned due to chemical saturation in homes where meth is produced as well as cleanup of lab sites. And there are stories in the annals of the meth epidemic of law enforcement personnel or firemen wounded or killed by lab site explosions or inhalation of chemical fumes.

While much of what is in this brief section is not considered a part of the strategy per se, the administration should be praised for its commitment to the drug endangered children, the DEC program. While DEC training has occurred in 28 States, the strategy asserts that ONDCP will work to achieve DEC training in all 50 States by 2008, with no further details offered. Hopefully, this excellent program will find more aggressive advocates on the Federal level.

[The prepared statement of Hon. Mark E. Souder follows:]

**Opening Statement
Chairman Mark Souder**

“Evaluating the Synthetic Drug Control Strategy”

**Subcommittee on Criminal Justice, Drug Policy
and Human Resources
Committee on Government Reform**

June 16, 2006

Good morning, and thank you for coming. We’ve been looking forward for some time now to the release of the Synthetic Drug Control Strategy, which was finally unveiled on June 1. Today, we will hear from several witnesses as to the strengths and weaknesses of this plan.

With the near-universal recognition that methamphetamine addiction has become an epidemic, it is imperative that the Federal government provide the best possible leadership and vision on this pressing social and law enforcement problem. State and local governments, as well as many private agencies devoted to helping families and communities cope with this scourge, have long complained that no matter how diligent non-Federal actors have been or could be, nothing can fill the void of national direction. Only Federal leadership will suffice, and many have awaited the new strategy with only guarded optimism. There seemed ample reason for concern as to the Administration’s commitment to a meth strategy. We can hardly forget a key presentation at the HHS-sponsored conference in Utah last August 19 which said, “We don’t need a war on methamphetamine.” Nor can we forget, as the New York Times reported on December 15, that FDA was working behind the scenes to block the Combat Meth Act.

This Strategy sets three primary goals: 1) a 15-percent reduction in methamphetamine abuse, 2) a 15-percent reduction in prescription drug abuse, and 3) a 25-percent reduction in domestic methamphetamine laboratories. The Strategy itself concedes that the first two goals may be met without much change in the Federal response given that recent trends already may be moving in that direction. The third goal is likely to be achieved due to tough restrictions on precursor chemicals set first by most of the states and now by Congress through the Combat Methamphetamine Epidemic Act, enacted this spring with virtually no support—and even some opposition from—the Administration.

With the national standard for precursor chemical control soon to be in full effect through the Combat Methamphetamine Epidemic Act, hopes are high for significant declines in domestic meth production. But meth will remain readily available unless international diversion of precursor chemicals can be stopped. This is borne out by the increased smuggling of meth across the southwest border, as Mexican drug traffickers move to exploit the decline in domestic meth production.

Accordingly, the Strategy begins with its international aspect, laying out three prongs: 1) attaining better information about the international trade in pseudoephedrine, 2) “swift and

effective implementation of the Combat Meth Act,” and 3) “continued law enforcement and border activities” and “continued partnership with Mexico.”

Regarding the first prong, the Administration has been taking some positive steps and recognizes that the problem cannot be tackled until its international nature and scope is fully understood. The challenge begins with this hopeful fact: the main precursor chemical—pseudoephedrine (PSE)—is produced in a handful of countries, chiefly in China, India and Germany. If exportation of PSE can be tracked and controlled from its sources, we could go a long way in choking off the essential ingredient needed by the criminal organizations now profiting by producing meth (chiefly in Mexico) and distributing it throughout this country. Fortunately, the Administration has been making diplomatic efforts through the UN Commission on Narcotic Drugs to persuade some reluctant governments that the meth epidemic is global, and that they should “get with the program.”

Though the implementation of the Combat Meth Act is the second prong of the international meth strategy, the Strategy re-states provisions of the law while not always describing how ONDCP will ensure that implementation will be carried out by the responsible agencies.

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Although the Strategy states its intent to “strengthen border protection,” it disturbingly fails to elaborate on this at all and is completely silent on what will be done in this area. In fact, the Strategy makes no mention of the Department of Homeland Security, which contains multiple agencies tasked with border security and counter-drug activities. This is almost shocking, considering that it now seems universally accepted within the Administration that approximately 80 percent of the meth being consumed in this country *is coming from Mexico*. Stopping meth smuggling from Mexico is clearly imperative, and the Strategy fails to explain why current border protection is adequate or just how such protection will be “strengthened.”

The domestic aspect of the Strategy leans heavily on the requirement of working closely with state and local officials. The Strategy acknowledges that the overwhelming majority of drug arrests and prosecutions (above 90 percent) are conducted by state and local authorities.

Nonetheless, we have been told by people we trust that there wasn’t much consultation or dialogue with the state and locals in crafting this Strategy. And while it touts the efforts of state and local authorities, the Administration seeks to drastically cut the Federal programs which have been essential to state and local law enforcement. For example, the Administration wants Congress to eliminate the Byrne Justice Assistance Grants program (JAG). In 2004, one-third of all meth labs seized were taken down by JAG-funded state and local drug task forces. The Strategy fails to explain how the state and local authorities can be expected to keep up this pace of lab seizures if the Administration succeeds in gutting the very programs that make it possible.

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We have quite a mix of witnesses with us today. Our first panel consists of the Honorable Scott Burns, Deputy Director for State and Local Affairs for the Office of National Drug Control Policy; the Honorable Uttam Dhillon, Director of Office of Counter-Narcotics Enforcement for the Department of Homeland Security; Joseph Rannazzissi, Deputy Assistant Administrator at DEA's Office of Diversion Control; and finally, we have Dr. Don Young, the Acting Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Our second panel will give us the state and local perspective. We have Mr. Ron Brooks, President of National Narcotic Officers' Associations Coalition; the Honorable Eric Coleman of the Oakland County Board of Commissioners in Michigan, representing the National Association of Counties; Dr. Lewis E. Gallant, the Executive Director of the National Association of State Alcohol and Drug Abuse Directors; Ms. Sherry Green, the Executive Director of the National Alliance for Model State Drug Laws; and finally, we have Ms. Sue Thau, the Public Policy Consultant for the Community Anti-Drug Coalitions of America.

Again, thank you all for coming from so many places across the country to be here today. We very much look forward to your testimony.

Mr. SOUDER. We have a good mix of witnesses with us today. Our first panel consists of the Honorable Scott Burns, Deputy Director for State and Local Affairs of the Office of National Drug Control Policy; the Honorable Tom Dhillon, Director of Counter-Narcotics Enforcement from the Department of Homeland Security; Joseph Rannazzissi, Deputy Assistant Administrator of DEA's Office of Diversion Control; and, finally, of Dr. Don Young, Acting Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

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Again, we thank you all for coming from so many places across the country to be here today. We look very much forward to your testimony. I would like to yield to our ranking member, Mr. Cummings.

Mr. CUMMINGS. Good morning, Mr. Chairman. Good morning, everyone. I want to thank you, Mr. Chairman, for holding this very important hearing today to evaluate the administration's recently announced synthetic drug control strategy.

Growing abuse of methamphetamine, other legal synthetic drugs like ecstasy and a variety of pharmaceutical drugs defines a major recent trend in drug abuse. The recent enactment of the Combat Meth Act and the administration's release of a synthetic drug control strategy earlier this month underscore the seriousness of the problem. Meth, in particular, has captured the attention of lawmakers and the media with the devastating impact it is having on entire communities in many areas of our country.

A powerfully addictive synthetic stimulant that has been around for more than 30 years, meth, until relatively recently, was concentrated in western States, including California, Arizona, and Utah. The recent eastward expansion of meth production, trafficking, and abuse has led to the drug suddenly becoming recognized as one of the primary drug threats facing our Nation today. Indeed, not since the introduction of crack cocaine into the streets of major cities like my city of Baltimore, New York, and Chicago, have we seen such an outcry for an aggressive antidrug response by the government at all levels.

A July 2005 report by the National Association of Counties, the Meth Epidemic in America, identifies meth as the No. 1 illegal drug threat facing most of the 500 counties that participated in a survey of local law enforcement agencies. Moreover, the drug's destructive impact on families has contributed to a significant increase in child welfare roles in hundreds of counties across the Nation according to the same report.

Meth is relatively unique in that it can be manufactured by laypeople using ingredients purchased in the U.S. retail stores and

recipes available on the Internet. This has enabled most of the production of U.S. consumed methamphetamine to occur domestically both in so-called super labs that produce large amounts of high purity meth, and in clandestine labs that are small enough to be operated in homes, apartments, hotel rooms, rented storage space, and trucks. The environmental damage caused by meth production can be severe, and the cost of cleaning up the toxic wastes from these sites is immense. Because the ingredients are extremely volatile in combination, labs also pose a grave risk of harm both to the so-called meth cooks who make the drug and to the individuals living in close proximity to the activity. Many labs are discovered only after an explosion has occurred. Law enforcement officers tasked with finding or dismantling labs are forced to share the risk.

All too often, the collateral victims of meth abuse are the young children of addicts and cooks. These children live with the constant risk of harm from explosions, exposure to toxic chemicals, and extreme familial neglect. As the National Association of Counties report and countless news reports have described, these conditions have led to a large number of children being taken from the custodial control of their parents and placed in foster care.

Sadly, the health and behavior effects that result from prenatal exposure to meth and from severe family neglect or abuse make the children of meth addicted parents especially challenging for foster families to care for and difficult to place. Absent effective treatment for the parents of displaced children, re-uniting families torn apart by meth may be almost impossible.

Meth abuse has not yet become a major problem in the communities of Baltimore City, in Baltimore and Howard Counties where I represent. But the rapid spread of meth production, trafficking, and abuse in the United States underscores the fact that America's drug problem affects all parts of this Nation, rural, suburban, and urban alike, and that no community is immune to the introduction of a dangerous new drug threat. Drugs, unlike people, do not discriminate on the basis of color, class, or geography.

States have been at the forefront of efforts to develop effective policies and strategies to combat the growth of meth abuse, production, and trafficking in the United States. States including Oklahoma have successfully used restrictions on retail sale of cold products containing meth precursor chemicals to drive down the volume of meth production in clandestine labs. Federal legislative efforts to address the meth epidemic, including the Combat Meth Act enacted earlier this year, similarly have focused largely on limiting over-the-counter access to products containing precursor chemicals as well as on limiting the illegitimate importation and exportation of meth precursor chemicals across the international borders.

The administration's new synthetic drug control strategy emphasizes these objectives, and I believe Congress and the administration should continue to pursue them. At the same time, Mr. Chairman, I believe it is difficult to overestimate the importance of education, prevention, and in particular, drug treatment as we attempt to stifle this growing epidemic.

Despite some popular notions to the contrary, research from the Center for Substance Abuse Treatment shows that meth addiction can be effectively treated, and that the benefits of treating meth

addiction are similar to the benefits derived from treating addiction to other drugs; use of the drug is sharply reduced, criminal activity and recidivism declined, employment status and housing status improve, and overall health improves. Ensuring that people who have become dependent upon meth have access to effective treatment is therefore essential to stopping this problem that is creeping across our country.

Unfortunately, it bears noting that the 53-page strategy announced by the administration devotes just 3½ pages to prevention and treatment combined. Indeed, several important programs that contribute to reducing demand for meth and other synthetic drugs are not even mentioned in the strategy, which is incredible. In the case of Safe and Drug Free Schools State grants, for example, this is no doubt because the problem has been targeted for elimination in the President's budget.

This leads to the broader concern that this strategy, even as it purports to be comprehensive, appears to reflect the same flawed balance of priorities embodied in the overall Federal drug control budget proposed by the President. Over the past 6 years, we have seen prevention and treatment dollars decrease from 47 percent to merely 35 percent of the Federal drug budget. Even programs that support Mexican drug enforcement at the State and local levels have been targeted for elimination or deep cuts, as funding for supply reduction efforts beyond our borders expands without solid justification. The High Intensity Drug Trafficking Areas Program, COPS meth grants, and the Byrne Justice Assistance grants, all critical programs, would be eroded or eliminated.

Given these facts, I think one of the central questions raised by today's hearing is this: Does the strategy genuinely reflect an ambitious forward-thinking effort to devise the most comprehensive and effective synthetic drug strategy our Federal drug policy efforts can muster? Or does it instead represent mere lumping together in one document of preexisting ideas, initiatives, and priorities inside a new glossy cover?

To help us answer these and other questions, we are fortunate to have appearing before us today representatives of several Federal agencies tasked with formulating and implementing various aspects of the synthetic drug strategy, as well as a number of outside organizations that contribute greatly to the Nation's antidrug efforts through their dedication and expertise. I look forward to hearing the testimony of all our witnesses concerning the content of the strategy, the manner in which it was formulated, and their perspectives on whether and to what extent the strategy adequately describes the best possible formula for beating back the growing threats of illegal synthetic drugs and prescription drug abuse.

Mr. Chairman, I thank you for your relentless attention to this issue, and I also thank each of our witnesses for appearing here today. With that, I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

**Opening Statement of
Representative Elijah E. Cummings, D-MD
Ranking Minority Member
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Committee on Government Reform
U.S. House of Representatives
109th Congress**

Hearing on "Evaluating the Synthetic Drug Control Strategy"

June 16, 2006

Mr. Chairman,

Thank you for holding today's important hearing to evaluate the Administration's recently announced Synthetic Drug Control Strategy.

The growing abuse of methamphetamine, other illegal synthetic drugs like Ecstasy, and a variety of pharmaceutical drugs defines a major recent trend in drug abuse. The recent enactment of the Combat Meth Act and the Administration's release of the Synthetic Drug Control Strategy earlier this month underscore the seriousness of the problem.

"Meth," in particular, has captured the attention of lawmakers and the media with the devastating impact it is having on entire communities in many areas of the country.

A powerfully addictive synthetic stimulant that has been around for more than thirty years, meth, until relatively recently, was concentrated in Western states including

California, Arizona and Utah. The recent eastward expansion of meth production, trafficking, and abuse has led to the drug's suddenly becoming recognized as one of the primary drug threats facing our nation.

Indeed, not since the introduction of crack cocaine into the streets of major cities like Baltimore, New York, and Chicago have we seen such an outcry for an aggressive anti-drug response by government at all levels.

A July 2005 report by the National Association of Counties, "The Meth Epidemic in America," identifies meth as the number one illegal drug threat facing most of the 500 counties that participated in a survey of local law enforcement agencies. Moreover, the drug's destructive impact on families has contributed to a significant increase in child welfare rolls in hundreds of counties across the nation, according to the same report.

Meth is relatively unique in that it can be manufactured by lay people using ingredients purchased in U.S. retail stores, according to recipes available on the Internet. This has enabled most of the production of U.S.-consumed methamphetamine to occur domestically -- both in so-called "superlabs" that produce large amounts of high-purity meth and in "clandestine" labs that are small enough to be operated in homes, apartments, hotel rooms, rented storage spaces, and trucks.

The environmental damage caused by meth production can be severe and the cost of cleaning up the toxic waste from these sites is immense. Because the ingredients are extremely volatile in combination, labs also pose a grave risk of harm both to the so-called “meth cooks” who make the drug and to individuals living in close proximity to the activity. Many labs are discovered only after an explosion has occurred. Law enforcement officers tasked with finding or dismantling labs are forced to share the risk.

All too often, the collateral victims of meth abuse are the young children of addicts and cooks. These children live with the constant risk of harm from explosions, exposure to toxic chemicals, and extreme familial neglect.

As the National Association of Counties report and countless news reports have described, these conditions have led to a large number of children being taken from the custodial control of their parents and placed into foster homes.

Sadly, the health and behavioral effects that result from prenatal exposure to meth and from severe family neglect or abuse make the children of meth-addicted parents especially challenging for foster families to care for and difficult to place. Absent effective treatment for the parents of displaced children, reuniting families torn apart by meth may be impossible.

Meth-abuse has not yet become a major problem in the communities of Baltimore City and Baltimore and Howard Counties that I represent. But the rapid spread of meth production, trafficking, and abuse in the United States underscores the fact that America's drug problem affects all parts of the nation – rural, suburban, and urban alike -- and that no community is immune to the introduction of a dangerous new drug threat. Drugs, unlike people, do not discriminate on the basis of color, class, or geography.

States have been at the forefront of efforts to develop effective policies and strategies to combat the growth of meth abuse, production, and trafficking in the United States. States including Oklahoma have successfully used restrictions on the retail sale of cold products containing meth precursor chemicals to drive down the volume of meth production in clandestine labs.

Federal legislative efforts to address the meth epidemic – including the Combat Meth Act enacted earlier this year – similarly have focused largely on limiting over the counter access to products containing precursor chemicals, as well as on limiting the illegitimate importation and exportation of meth precursor chemicals across international borders. The Administration's new Synthetic Drug Control Strategy emphasizes these objectives and I believe Congress and the Administration should continue to pursue them.

At the same time, Mr. Chairman, I believe it is difficult to overestimate the importance of education, prevention, and, in particular, drug treatment as we attempt to stifle this growing epidemic.

Despite some popular notions to the contrary, research from the Center for Substance Abuse Treatment shows that meth addiction can be effectively treated and that the benefits of treating meth addiction are similar to the benefits derived from treating addiction to other drugs: use of the drug is sharply reduced, criminal activity and recidivism decline, employment status and housing status improve, and overall health improves.

Ensuring that people who have become dependent upon meth have access to effective treatment is therefore essential to stopping this problem that is creeping across our country.

Unfortunately, it bears noting that the 53-page Strategy announced by the Administration devotes just three and a half pages to prevention and treatment *combined*. Indeed, several important programs that contribute to reducing demand for meth and other synthetic drugs are not even mentioned in the Strategy.

In the case of Safe and Drug-Free Schools state grants, for example, this is no doubt because the program has been targeted for elimination in the President's budget.

This leads to the broader concern that this Strategy, even as it purports to be comprehensive, appears to reflect the same flawed balance of priorities embodied in the overall federal drug control budget proposed by the President.

Over the past six years, we have seen prevention and treatment dollars decrease from 47% to merely 35% of the federal drug budget. Even programs that support domestic drug enforcement at the state and local levels have been targeted for elimination or deep cuts, as funding for supply reduction efforts beyond our borders expands without solid justification. The High Intensity Drug Trafficking Areas program, COPS meth grants, and Byrne Justice Assistance Grants – all critical programs, would be eroded or eliminated.

Given these facts, I think one of the central questions raised by today's hearing is this: does the Strategy genuinely reflect an ambitious, forward-thinking effort to devise the most comprehensive and effective synthetic drug strategy our federal drug policy experts can muster? Or does it instead represent the mere lumping together, in one document, of pre-existing ideas, initiatives, and priorities, inside a new glossy cover?

To help us answer these and other questions, we are fortunate to have appearing before us today representatives of several federal agencies tasked with formulating and implementing various aspects of the Synthetic Drug strategy, as well as a number of outside organizations that

contribute greatly to the nation's anti-drug efforts through their dedication and expertise.

I look forward to hearing the testimony of all of our witnesses concerning the content of the Strategy, the manner in which it was formulated, and their perspectives on whether and to what extent the Strategy adequately describes the best possible formula for beating back the growing threats of illegal synthetic drugs and prescription drug abuse.

Thank you, Mr. Chairman, for your relentless attention to this issue and thanks also to each of our witnesses for sharing their knowledge and perspectives with us today.

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Mr. SOUDER. Ms. Watson.

Ms. WATSON. Mr. Chairman, I want to thank you for holding this hearing that is critical to the understanding of the administration's heavily anticipated synthetic drug control strategy.

Eliminating drug smuggling and distribution throughout the United States is vital in keeping our communities safe. There have been several programs unveiled by the public and nonprofit sectors throughout the United States. These programs are going to be the next new innovation in helping us eradicate our drug problem. Some have been good and some have been not so good. None of them have been the ultimate problem solver. The new strategy set forth by the Office of the National Drug Control Policy is very ambitious but not impossible if funding and resources are at a sufficient level.

The three goals set forth in this strategy are excellent. If we could accomplish what the plan sets out, including 15 percent reduction in prescriptive drug abuse, 25 percent reduction in methamphetamine labs, and 15 percent reduction of methamphetamine use, it would be of great benefit to our people and our streets. While they are great goals, the question of how they are going to be met with the administration's funding cut proposals need to be addressed. Can these goals be accomplished when the administration wants a \$23.6 million cut in the Justice Department's community-oriented policing services meth hot spots program? Can these goals be met when the administration wants to eliminate the Edward Byrne Memorial Justice Assistance grant program?

My family personally has been affected by meth use. My niece at the end of May passed due to the abuse of this killer drug. It affected her vital organs, she had a hole in her heart, from age 19 to age 22. We suffered along with her. The treatment programs we enrolled her in did absolutely nothing. Every method that we as a family and friends used to try and help her did not work. Prevention could have saved her. We lived in an upscale community in Sacramento, she lived with me, and we were right there. Did not notice until too late. Tried to save her and failed. So a focus on prevention so users would not have to face treatment is essential.

The administration states that prevention is an essential component of its three pillars of antidrug efforts. The decline of funding in this area has cast major doubts on their claim. If the administration is serious about creating a solution to this problem, fund each mandate sufficiently.

And so I want to thank the panelists for your willingness to come and testify before this subcommittee so we can understand how this new drug control strategy will be implemented in the midst of major cuts in funding. I don't want to see anyone suffer as my niece and her loved ones did.

We must realize that drug use is international in scope, and for every one life that is lost to drugs, many are affected. So, Mr. Chairman, thank you so very much for this hearing today.

Mr. SOUDER. Thank you. And thank you for your continued aggressive and active interest in this committee. It has truly been a bipartisan effort as we move through this and other drugs, and we are looking forward to our hearing on treatment as well that is coming up in just a few weeks.

First, I would like to ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record, and that any answers to written questions provided by the witnesses also be included in record. Without objection, it is so ordered. I also ask unanimous consent that all exhibits, documents, and other materials referred to by Members and the witnesses may be included in the hearing record, and that all Members be permitted to revise and extend their remarks. Without objection, it is so ordered.

Our first panel is composed of the Honorable Scott Burns, Deputy Director for State and Local Affairs at the Office of National Drug Control Policy; the Honorable Tom Dhillon, Director of the Office of Counter Narcotics Enforcement, Department of Homeland Security; Mr. Joseph Rannazzissi, Deputy Assistant Administrator of the Office of Diversion Control of DEA, Drug Enforcement Administration; and Dr. Don Young, Acting Assistant Director or Secretary for Planning and Evaluation for the Department of Health and Human Services.

As an oversight committee, it is a standard practice to ask witnesses to testify under oath. If you will raise your right hands, I will administer the oath to you.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that all the witnesses have answered in the affirmative.

Mr. Burns, thank you for joining us. You are now recognized for 5 minutes.

STATEMENTS OF SCOTT BURNS, DEPUTY DIRECTOR FOR STATE AND LOCAL AFFAIRS, OFFICE OF NATIONAL DRUG CONTROL POLICY; UTTAM DHILLON, DIRECTOR, OFFICE OF COUNTER-NARCOTICS ENFORCEMENT, DEPARTMENT OF HOMELAND SECURITY; JOSEPH RANNAZZISSI, DEPUTY ASSISTANT ADMINISTRATOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION; AND DR. DON YOUNG, ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF SCOTT BURNS

Mr. BURNS. Thank you, Mr. Chairman, Ranking Member Cummings, Congresswoman Watson, thank you for the opportunity to appear before you today to discuss the administration's synthetic drug control strategy. I want to thank the subcommittee for its strong bipartisan commitment to reducing the illicit use of all drugs.

The Synthetic Drug Control Strategy was released on June 1st, and represents a firm commitment by the administration to work toward ambitious and concrete reductions in the illicit use of methamphetamine and prescription drugs as well as in the number of domestic methamphetamine laboratories.

Specifically, the strategy aims to reduce methamphetamine use by 15 percent over 3 years, illicit prescription drug use by 15 percent over 3 years, and domestic methamphetamine laboratory seizures by 25 percent over 3 years. In these respects, it is similar to

the administration's National Drug Control Strategy in that it is both ambitious and achievable.

The synthetic strategy also recognizes that supply and demand are the ultimate drivers in an illicit drug market, and that a balanced approach incorporating prevention, treatment, and market disruption initiatives is the best way to reduce the supply of and the demand for illicit drugs.

The most urgent priority of the Federal Government toward reducing the supply of methamphetamine in the United States will be to tighten the international market for chemical precursors, such as pseudoephedrine and ephedrine, as you know, used to produce this drug. Toward this end, the Office of National Drug Control Policy Director John Walters has met with Ambassadors from China, India, and the European Union. The administration worked with allies in the international community to draft, promote, and adopt a resolution on synthetic drug precursors, particularly methamphetamine precursors, at the annual meeting of the United Nations Commission on Narcotic Drugs.

Other important parts of the synthetic strategy are swift and effective implementation of the Combat Meth Act and our continued partnership with Mexico. Domestically, the synthetic strategy recognizes the critical role that State and local law enforcement as well as treatment and prevention professionals play in addressing the methamphetamine threat. And, in fact, I would be remiss if I did not recognize the role that State and local policy and law enforcement officials have played in addressing, in particular, the problem of methamphetamine production in the United States.

The synthetic strategy contains a 10-part plan to enhance the Federal partnership with State and local agencies related to methamphetamine, focusing on initiatives such as helping drug endangered children programs expand nationwide, holding four regional and one national methamphetamine conference, and better sharing of data and assisting States in developing their own regional drug control strategies related to synthetic drugs.

The synthetic strategy also addresses prescription drug abuse. The administration's ambitious goal of reducing prescription drug abuse by 15 percent by the end of 2008 must balance two general policy concerns: First, to be aggressive in reducing overall user abuse; and, second, to avoid overreaching and avoid making lawful acquisition of medications unduly cumbersome. The seriousness of this problem cannot be overstated as prescription drug abuse has risen to become the second most serious drug problem when measured in terms of prevalence, with past year abusers numbering approximately 6 million.

The administration will continue to target doctor shopping and other prescription fraud as well as illegal on-line pharmacies, continue to thwart thefts and burglaries from homes and pharmacies, focus on strategies to combat stereotypical drug dealing, and to investigate and prosecute those in the medical profession to be distinguished from the vast majority that prescribe appropriately, who are engaged in illegal overprescribing for profit.

Mr. Chairman, Ranking Member Cummings, Congresswoman Watson, I would like to personally thank you and members of the subcommittee and the members of the House and Senate meth cau-

cuses for your individual and combined efforts in addressing these issues. I look forward to working with you and members of this subcommittee as the strategy is implemented, and conferring along the road as we strive together to meet the goals we have set forth on behalf of the American people. Thank you. And I look forward to any questions the subcommittee may have.

Mr. SOUDER. Thank you.

[The prepared statement of Mr. Burns follows:]

Statement by Scott Burns
Deputy Director for State and Local Affairs
White House Office of National Drug Control Policy
Before the House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources
June 16, 2006

Chairman Souder, Ranking Member Cummings, and Distinguished Members of the Subcommittee:

Thank you for the opportunity to appear before you today to discuss the Administration's *Synthetic Drug Control Strategy*. I thank the Subcommittee for its strong bipartisan commitment to our shared national goals of reducing the illicit use of methamphetamine and prescription drugs, and reducing the number of domestic methamphetamine laboratories. The Administration welcomes the opportunity to introduce the first-ever *Synthetic Drug Control Strategy*, a national effort to reduce the illicit demand for, and supply of, synthetic drugs like methamphetamine and prescription drugs.

Overview

The *Synthetic Drug Control Strategy* is a commitment by the Administration to work toward ambitious and concrete reductions in the illicit use of methamphetamine and prescription drugs, as well as in the number of domestic methamphetamine laboratories. Specifically, the Strategy aims to reduce illicit methamphetamine use by 15% over three years, illicit prescription drug use by 15% over three years, and domestic methamphetamine laboratory seizures by 25% over three years. The baseline year for all three goals is 2005.

The fundamental principles of the *Synthetics Strategy* are identical to those introduced in the Administration's *National Drug Control Strategy*: that supply and demand are the ultimate drivers in all illicit drug markets, and that a balanced approach incorporating prevention, treatment and market disruption initiatives (such as interdiction, arrests, prosecutions, and regulatory interventions) is the best way to reduce the supply of, and demand for, illicit drugs. Similar to the *National Strategy*, the *Synthetics Strategy* sets goals for reducing illicit drug use at a rate that approximates five percent per year.

Traditionally, Administrations have avoided promulgating strategies which relate to a specific drug or category of drugs. The *Synthetics Strategy* was developed for the American people due to the recognition that synthetic drugs like methamphetamine pose unique dangers, both in illicit use and production. Synthetic drugs also contain unique vulnerabilities, thus requiring a distinct strategy.

The *Synthetics Strategy* describes how those goals will be attained. It is both domestic and international in scope, and discusses priorities ranging from international diplomatic efforts to reduce the diversion of precursor chemicals used to make methamphetamine; state-led approaches to reducing domestic methamphetamine laboratories; the implementation of the Combat Methamphetamine Epidemic Act of 2005; treatment and prevention initiatives; and various regulatory tools to address the problem of prescription drug diversion and abuse.

The *Synthetics Strategy* is also intended as a final report on the *National Synthetic Drugs Action Plan*, which was released in October 2004. That document contained 46 recommendations for government action. The *Synthetics Strategy* reports that 45 of the 46 recommendations are either completed or ongoing (some, by their nature, were not intended to terminate at a specific point in time). The one recommendation not included in that category pertains to illicit online pharmacies, and the *Synthetics Strategy* recognizes the need for new Federal legislation to address the problem. The Synthetic Drugs Interagency Working Group, the interagency structure which developed the Administration's *Synthetic Drug Control Strategy*, will continue to monitor and discuss the implementation of those 46 recommendations and the overall *Synthetics Strategy* itself.

Process

The *Synthetic Drug Control Strategy* was developed by the Synthetic Drugs Interagency Working Group (SDIWG), an interagency team of Administration officials composed of the Office of National Drug Control Policy, the Departments of State, Justice, Homeland Security, Health and Human Services, Transportation, the Environmental Protection Agency, and the Office of the United States Trade Representative. Director Walters appointed me co-chair of the SDIWG with senior officials from the Departments of Justice and Health and Human Services. The SDIWG met approximately every two months to review synthetic drug control policy, coordinate its implementation, and discuss which initiatives should be formalized as Administration policy in the *Synthetic Drug Control Strategy*.

ONDCP staff responsible for the drafting of the *Synthetics Strategy* consulted with Federal, State and local officials prior to and during the drafting process in three significant ways. First, every year, ONDCP staff tasked with writing the *National Drug Control Strategy* request input in writing from experts throughout the country, including members of Congress and State/local law enforcement. Because the 2006 *National Drug Control Strategy* and the *Synthetic Drug Control Strategy* were drafted during the same time frame, ONDCP staff culled out and reviewed all responses related to synthetic drugs such as methamphetamine or prescription drugs. Many of these suggestions were presented to the SDIWG and ultimately incorporated into the *Synthetic Drug Control Strategy*.

Second, ONDCP staff reached out to specific groups or individuals with known experience and expertise in synthetic drug control policy. For example, on November 14th, 2005, as the drafting process began, ONDCP staff sent an email to every High Intensity Drug Trafficking Area (HIDTA) program director requesting the views of the HIDTA Directors and HIDTA-associated law enforcement officials "as to how the Administration should fight synthetic drugs like methamphetamine over the next three years" for the purpose of drafting an Administration strategy related to synthetic drugs. In addition to a few individual responses, a collective response was received, reviewed by ONDCP staff and SDIWG leadership, and ultimately several of the HIDTA Directors' suggestions were incorporated into the *Synthetic Drug Control Strategy*. Similarly, in developing two initiatives in the *Synthetics Strategy* which aim to benefit State and local efforts – holding four regional methamphetamine conferences and developing Prescription Drug Monitoring Programs – SDIWG leadership and ONDCP staff responsible for drafting the *Synthetics Strategy* have worked, and are continuing to work, with senior staff at the National Alliance for Model State Drug Laws, an organization with expertise in both topics.

Third, one of my responsibilities as Deputy Director for State and Local Affairs is to be a liaison with state and local law officials. Thus, in my dual role as Deputy Director for State and Local Affairs and co-chair of the SDIWG, I have traveled to nearly all fifty states over the last four years on behalf of the President and Director Walters, and the majority of my speeches or meetings concern, at least in part, synthetic drugs such as methamphetamine or prescription drugs. These meetings have afforded me the opportunity to discuss Administration policy, but perhaps more importantly were an invaluable opportunity to consult with State and local officials about the challenges they face related to methamphetamine and other drugs. These discussions were critical to the development of the *Synthetic Drug Control Strategy*.

Measuring Performance

The three overarching goals of the *Synthetics Strategy* are intended to guide the Administration's efforts related to the control of synthetic drugs for the remainder of President Bush's second term. As such, those three goals target certain reductions in illicit drug use or production by the year 2008. The Administration will report annually as to progress in meeting those objectives, using the National Survey on Drug Use and Health to measure use, and the Drug Enforcement Administration's El Paso Intelligence Center's Clandestine Laboratory Seizure Service to measure domestic methamphetamine laboratory incident reports.

Continuing Progress: A Status Report

The *Synthetics Strategy* describes the results from the implementation of the President's *National Drug Control Strategy* and the continuing challenges we face regarding synthetic drugs. Notable trends include decreases in the past-month use of any illicit drug among youth¹ by 19 percent² and past month use of methamphetamine use by 36 percent³ since 2001. Similarly, the illicit use of steroids dropped dramatically among youth from 2001 to 2004 with the illicit use of steroids down 38 percent, 37 percent, and 30 percent for lifetime, past year, and past month use, respectively. The past-month use among teens of hallucinogens and LSD use is down by nearly two-thirds, as is past-month Ecstasy (3, 4 methylenedioxy-methamphetamine, or MDMA) use. Marijuana use has also dropped in all three categories: 13 percent for lifetime use, 15 percent for past year use, and 19 percent for 30-day use, decreasing 28 percent among 8th graders (from 9.2 percent to 6.6 percent), and 23 percent among 10th graders (from 19.8 percent to 15.2 percent).

With respect to domestic methamphetamine production, after an increase in domestic methamphetamine laboratories observed in the 1990s and early 2000s, domestic laboratory numbers appear to have taken a sharp downturn in 2005, thanks largely to innovative strategies employed by the States. After peaking with more than 17,500 laboratory incidents reported in 2004, data for 2005 shows a substantial and significant reduction in methamphetamine laboratory incidents. Since 2002, the number of domestic "super labs" reported—those methamphetamine laboratories with a production capacity estimated at 10 or more pounds within a 24-hour period—has posted a dramatic decline, falling from 142 in 2002 to just 35 in 2005, due largely to Federal law enforcement interventions at our shared border with Canada, and to

¹ "Youth" refers to 8th, 10th, and 12th graders, the populations measured by the *Monitoring the Future* study.

² 2005 *Monitoring the Future*. Special analysis conducted for the Office of National Drug Control Policy by MTF researchers.

³ Ibid.

cooperation with Canadian authorities to stem the smuggling of pseudoephedrine into the United States. The Administration seeks to continue such reductions with the implementation of the Combat Methamphetamine Epidemic Act of 2005 (the “Combat Meth Act”).

Methamphetamine

The most urgent priority of the Federal government toward reducing the supply of methamphetamine in the United States will be to tighten the international market for chemical precursors, such as pseudoephedrine and ephedrine,⁴ used to produce the drug. Most of the methamphetamine used in America—probably between 75 and 85 percent—is made with chemical precursors that are diverted at some point from the international stream of commerce. The remainder of the methamphetamine is produced from chemical precursors that are purchased at the wholesale or retail level and diverted for use in illicit production in the United States.

Toward this end, ONDCP Director John Walters has met with Ambassadors from China, India and the European Union. The Administration worked with allies in the international community to draft, promote, and adopt a resolution on synthetic drug precursors, including methamphetamine precursor chemicals, at the annual meeting of the United Nations Commission on Narcotic Drugs (CND), which is the central policy-making body within the United Nations system dealing with drug-related matters. The CND supervises the application of international conventions and agreements regarding narcotic drugs and provides advice on the control of narcotic drugs, psychotropic substances and their precursors. In March 2006, the CND member states unanimously adopted the synthetic drug precursor resolution proposed by the United States and cosponsored by a number of CND member nations.

The second prong of the Federal government’s strategy to tighten the international precursor market involves implementation of the Combat Meth Act. This important legislation, passed by Congress and recently signed by the President, contains a comprehensive set of regulations designed to help tighten the market for pseudoephedrine and other chemical precursors to methamphetamine. The *Synthetics Strategy* provides detail as to the various requirements of the new law, which agencies in the Administration are responsible for implementation, and along what timeline the various requirements will be implemented.

The third prong of the international precursor strategy is to continue working closely with Mexico through aggressive law enforcement activities against precursor trafficking and methamphetamine production and trafficking, and to strengthen border protection at our shared border with Mexico. Improving our bilateral efforts with Mexico to prevent methamphetamine smuggling, working with Mexican law enforcement, and encouraging the Mexican government to reduce precursor chemical diversion are also called for in the Combat Meth Act.

Domestically, the *Synthetics Strategy* recognizes the critical role that state and local law enforcement, as well as treatment and prevention professionals, play in addressing the methamphetamine threat. The *Synthetics Strategy* contains a ten-part plan to enhance the Federal partnership with state and local agencies related to methamphetamine. For example, the plan encourages States to include in their comprehensive drug control strategies a plan to address

⁴ This document will frequently use the term pseudoephedrine to generically describe three chemicals commonly used as methamphetamine and amphetamine precursors: pseudoephedrine, ephedrine, and phenylpropanolamine.

regional methamphetamine and controlled substance prescription drug abuse threats; expand Drug Endangered Children programs and Prescription Drug Monitoring Programs nationwide; continue ambitious law enforcement training programs related to methamphetamine; and improve data collection and sharing of best practices related to illicit methamphetamine use and production.

The President's Fiscal Year '07 Federal Drug Control Budget seeks increases in funding for methamphetamine lab clean-up (from \$20 million to \$40 million) and an increase in funding for Drug Courts from approximately \$10 million to \$70 million. The budget also provides \$41.6 million in methamphetamine-targeted treatment research and a dedicated \$25 million for methamphetamine treatment services within the Access to Recovery program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (HHS). The High Intensity Drug Trafficking Area (HIDTA) program continues to attack methamphetamine traffickers and domestic labs, as evidenced by the fact that some 96 specific HIDTA initiatives target methamphetamine, more than any other specific drug in America.

Treatment and prevention initiatives are critically important elements of the *Synthetics Strategy*. The National Institute for Drug Abuse (NIDA) is continuing to research the most effective way of treating methamphetamine addiction. Additionally, in spring 2006, the SAMHSA held two regional meetings with States on methamphetamine issues. The summits were specifically designed for those State agency staff involved in developing, regulating, and funding methamphetamine treatment. The Administration will hold four regional methamphetamine summits in partnership with the National Alliance for Model State Drug Laws.

Additionally, the Administration continues to support drug courts as an innovative approach for helping nonviolent offenders achieve a drug-free life. The coercive power of the courts, together with the support of family, friends, and counselors, has been shown to be an effective mechanism for achieving drug abstinence and reducing recidivism. One study has shown that 43.5 percent of offenders who did not participate in a drug court program are rearrested for a serious offense, while only 16.4 percent of drug court graduates are rearrested.⁵ For fiscal year 2007, the President has requested a significant increase in support to States for drug courts above the enacted fiscal year 2006 level.

SAMHSA's Access to Recovery (ATR) program is a voucher-based program intended to expand access to innovative drug and alcohol and to effective substance abuse treatment and recovery support services, including faith-based providers. In August of 2004, SAMHSA awarded grants to 14 States and one tribal organization. It is estimated that this cohort of grantees will serve approximately 125,000 individuals over the three-year life of the grants. In the President's 2007 budget, the ATR program includes approximately \$25 million in vouchers for methamphetamine treatment that will fund approximately 10 grants to State applicants whose epidemiological data indicate high methamphetamine prevalence.

Moreover, SAMHSA announced 11 new, three-year grants to provide treatment for methamphetamine abuse and other emerging drugs for adults residing in rural

⁵ J. Roman, W. Townsend, and A. Bhati (2003, July). National estimates of drug court recidivism rates. Washington, DC: National Institute of Justice, U.S. Department of Justice. These figures are for all drug court participants, not just those with a history of methamphetamine use.

communities. These grants total \$5.4 million for the first year and approximately \$16.2 million for all three years.

With respect to prevention, NIDA continues to support research to develop effective drug abuse prevention programs. In 2003, NIDA revised its *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*, which presents updated research-based prevention principles, an overview of program planning, and critical first steps for those learning about prevention. Because the goal of drug abuse prevention efforts is to prevent the initiation of drug use, most of these prevention efforts are not targeted toward any specific drug. However, recent results also demonstrate that these universal prevention programs can be effective at reducing methamphetamine abuse specifically.

Starting in late 2005, ONDCP and the Partnership for a Drug-Free America launched a new television advertising campaign to highlight the dangers of methamphetamine. The anti-methamphetamine media campaign and the utilization of these commercials by communities most affected by methamphetamine are important components of the Administration's plan to prevent the illicit use of the drug among both youth and the general population. The anti-methamphetamine campaign was launched in Springfield, Missouri, and is being expanded to 23 cities nationwide.

Prescription Drug Abuse

The Synthetic Strategy also addresses prescription drug abuse, often called the "non-medical use of prescription drugs." The Administration's ambitious goal of reducing prescription drug abuse by 15% by the end of 2008 must balance two general policy concerns: first, to be aggressive in reducing overall user abuse and, second, to avoid overreaching and avoid making lawful acquisition of prescription medications unduly cumbersome. The seriousness of this problem cannot be overstated, as prescription drug abuse has risen to become the second most serious drug problem measured in terms of prevalence, with past-year abusers numbering approximately 6 million.

The Administration, again in cooperation with Federal, State and local partners and with the overall strategy of prevention/education, treatment and law enforcement in mind, will continue to target doctor shopping and other prescription fraud as well as illegal online pharmacies; continue efforts to thwart thefts and burglaries from homes and pharmacies; focus on strategies to combat stereotypical drug dealing (selling of pills from a dealer to user); and investigate and prosecute those in the medical profession -- as distinguished from the vast majority that prescribe appropriately -- who are engaged in illegal overprescribing for profit. We will continue to work with those states that have yet to implement a prescription monitoring program.

Conclusion

Mr. Chairman, I would like to personally thank you, the members of the Subcommittee and the members of the House and Senate Meth Caucuses for your individual and combined efforts in addressing the issues. I look forward to working closely with members as the Strategy is implemented and conferring along the road as we strive together to meet the goals we have set forth on behalf of the American people. Thank you and I look forward to any questions you may have regarding the *Synthetic Drug Control Strategy*.

Mr. SOUDER. Mr. Dhillon.

STATEMENT OF UTTAM DHILLON

Mr. DHILLON. Thank you, Mr. Chairman, Ranking Member Cummings, and Representative Watson. Thank you for the opportunity to appear before you today to testify on behalf of the Department of Homeland Security in support of the administration's National Synthetic Drug Control Strategy. And I look forward to working with this subcommittee in our common fight against the illicit use of methamphetamine and other synthetic drugs.

As the Director of Office of Counter Narcotics Enforcement, it is my responsibility to coordinate counternarcotics policy within the Department of Homeland Security and between the Department and other Federal departments and agencies.

I understand that methamphetamine abuse is a serious issue facing our Nation. According to a recent report by the National Association of Counties, 58 percent of counties surveyed said that methamphetamine was their largest drug problem, followed by cocaine, marijuana, and heroin.

Increasingly, the methamphetamine that supplies the U.S. drug market is produced internationally, and the Department of Homeland Security is committed to stopping the flow of methamphetamine and its precursors into our country. The administration's Synthetic Drug Control Strategy, like the National Drug Control Strategy, postulates a balanced approach by incorporating prevention, treatment, and market disruption initiatives as the best courses of action to reduce the supply of, and demand for, illicit drugs.

The Department of Homeland Security is in a unique position to focus on market disruption through the strategic goals outlined in the Department's Secure Border Initiative [SBI]. The Department of Homeland Security's Secure Border Initiative is a comprehensive approach to border control and enforcement through the integration of technology, infrastructure, communications, and command and control designed to disrupt and dismantle criminal organizations by preventing and deterring cross-border crime including but not limited to illicit drugs. SBI will provide a comprehensive multi-year plan for more agents to patrol our borders, secure our ports of entry, and enforce immigration laws as well as providing a comprehensive and systemic upgrading of the upgrading used in controlling the border, including increased manned aerial assets, expanded use of unmanned aerial vehicles, and next generation detection technology.

Through SBI, the Department of Homeland Security has developed a Border Enforcement Security Task Force [BEST], and now has a practical vehicle to directly partner with State and local law enforcement officials to combat drug trafficking and border violence. BEST is charged with sharing information, developing priority targets, and executing coordinated law enforcement operations to enhance border security. By establishing a new connectivity between the Department's intelligence community and law enforcement, BEST provides a focused response to intelligence driven identified targets such as criminal organizations that violate the

border, and will improve the Department's overall effectiveness against the full range of criminal activity along the border.

The Department of Homeland Security fully embraces its counternarcotics mission, and will do its part to ensure the success of the Synthetic Drug Control Strategy by working cooperatively with our Federal, State, and local law enforcement partners tasked with combating the flow of illicit drugs into the United States.

Thank you. And I look forward to answering your questions.

Mr. SOUDER. Thank you very much.

[The prepared statement of Mr. Dhillon follows:]

Statement of Uttam Dhillon
Director, Office of Counternarcotics Enforcement
United States Department of Homeland Security
“The National Synthetic Drug Control Strategy”
Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources
2154 Rayburn House Office Building
June 16, 2006

Chairman Souder, ranking member Cummings, and distinguished Subcommittee members, thank you for the opportunity to appear before you today to testify on behalf of the Department of Homeland Security in support of the Administration’s National Synthetic Drug Control Strategy, and I look forward to working with this Subcommittee in our common fight against the illicit use of methamphetamine and other synthetic drugs.

As the Director of the Office of Counternarcotics Enforcement, it is my responsibility to coordinate policy and operations within the Department, between the Department and other Federal departments and agencies, and between the Department and State and local agencies with respect to stopping the entry of illegal drugs into the United States.

I understand that methamphetamine abuse is a serious issue facing our nation. According to a recent report by a national association, 58% of Counties surveyed said that methamphetamine was their largest drug problem followed by cocaine (19%), marijuana (17%), and heroin (3%). Increasingly, the methamphetamine that supplies the U.S. drug market is produced internationally. The Department of Homeland Security is committed to stopping the flow of methamphetamine and its precursors from entering the United States in support of national drug control efforts. That commitment was demonstrated within the past two weeks by Customs and Border Patrol Officers who, on Saturday, June 3rd, arrested a 36-year-old man from Nogales, Mexico in connection with a failed attempt to smuggle almost 30 pounds of methamphetamine into our country.

The Administration’s 2006 National Synthetic Drug Control Strategy presents a roadmap to attack the serious threat to our Nation posed by methamphetamine and its precursors and sets specific goals to reduce methamphetamine use.

According to the Synthetic Drug Control Strategy, the Federal government’s most urgent priority toward reducing the supply of methamphetamine in the United States will be to tighten controls in the international market for chemical precursors, such as pseudoephedrine and ephedrine, used to produce the drug and to enhance law enforcement efforts focused at controlling the illicit trade in methamphetamine and its precursors. According to recent estimates, between 75 and 85 percent of the methamphetamine used in America is made using chemical precursors that were diverted at some point from the international stream of commerce. The remainder is produced from chemical precursors that are purchased at the wholesale or retail level and diverted for use in illicit production in the United States.

There are several components to the Federal government’s strategy to effectively respond to the international market for pseudoephedrine and similar precursor chemicals. One of these components involves obtaining better information about the international trade in methamphetamine and its precursors. Another component focuses on the implementation of the Combat Methamphetamine Epidemic Act of 2005. A third component addresses the need for law enforcement and border control activities, including a continued partnership with Mexico.

In order to more effectively address the problem of methamphetamine trafficking, we must continually work to improve our understanding of the methamphetamine market and the supply chain that supports that market. After leaving the exporting country, precursor chemicals are sometimes diverted to a transit country where they leave the legitimate stream of commerce. At some point thereafter, the precursors are used to produce the finished product – methamphetamine – at clandestine labs. Following this production, the methamphetamine comes across the border into the United States. We, as well as our foreign law enforcement counterparts, must understand where these chemicals are produced, how much is produced, and where it leaves the stream of legitimate commerce.

Another component to the Synthetic Drug Control Strategy involves utilizing the comprehensive set of guidelines set forth in the Combat Methamphetamine Act to help tighten the market for pseudoephedrine and other chemical precursors to methamphetamine in order to improve our ability to prevent illicit diversion of precursors in the international market. Furthermore, DEA will promulgate regulations based on the authority set forth in the Combat Methamphetamine Act to tighten the market for precursor chemicals. In addition, the Act sets a nationwide baseline standard for the retail sale of products containing pseudoephedrine and eliminates loopholes in the law that methamphetamine traffickers exploit.

A third element of the Synthetic Drug Control Strategy is to strengthen border protection at our shared border with Mexico and to continue working closely with Mexico through aggressive law enforcement activities against precursor trafficking and methamphetamine production and trafficking. The United States has been helping Mexico train and equip methamphetamine-focused law enforcement teams to combat the spread of methamphetamine production in Mexico. The Administration will continue its efforts to assist Mexico to improve its enforcement and investigative capabilities.

In the meantime, United States law enforcement agencies continue to seize increasing amounts of methamphetamine at our Southwest Border. Continued aggressive law enforcement efforts, implemented concurrently with efforts to tighten the market for chemicals used to make methamphetamine, are critical toward permanently impairing the methamphetamine market. During FY 2005, Immigration and Customs Enforcement Special Agents conducted counternarcotics investigations associated with the seizure of approximately 3,907 pounds of methamphetamine, 113,533 pounds of ephedrine and 2,039 pounds of other precursor chemicals. These totals include investigations independently initiated by ICE as well as investigations initiated as a result of CBP seizures at or between U.S. ports of entry.

Another aspect of the Administration's strategy is to support the important role that Federal, State, and local law enforcement have in combining intelligence against the operators of the large laboratories and trafficking networks. Specifically, American law enforcement agencies are, through traditional law enforcement activities and intelligence sharing, well placed to identify and target methamphetamine trafficking operations by analyzing the pattern of illicit chemical shipments. In a recent example of a successful investigation, on April 21, 2006, CBP officers at an Arizona port of entry searched a vehicle attempting to enter the United States and discovered approximately 70 pounds of methamphetamine. ICE Special Agents responded to the port of entry and arrested the driver, who agreed to participate in a controlled delivery. ICE agents conducted a controlled delivery of the methamphetamine to Phoenix, Arizona, by delivering the vehicle to members of the smuggling organization, resulting in four arrests and the seizure of approximately \$12,000. Agents then executed search warrants at two residences resulting in the seizure of approximately \$250,000 and a

small amount of cocaine. Subsequently, ICE agents placed lookouts for all identified members of this smuggling organization. As a result of these lookouts, CBP officers apprehended an additional member of the organization and seized an additional 44.5 pounds of methamphetamine.

Intelligence sharing is important because it responds to a simple truth about the illicit methamphetamine market: those organizations that are making the largest amounts of methamphetamine have a clear vision of the entire production and distribution scheme, starting from the point the pseudoephedrine is legally produced, to its smuggling, conversion into methamphetamine, distribution, and ultimate consumption, as well as the financial aspects associated with this process. To succeed in disrupting this market, law enforcement must understand and respond to the complete market plan of the traffickers. Intelligence-based initiatives that capture, assess, coordinate, and share information from Federal, State, and local agencies are the most effective means of accomplishing this objective.

The Administration's Synthetic Drug Control Strategy like the National Drug Control Strategy, postulates a balanced approach by incorporating prevention, treatment and market disruption initiatives as the best courses of action to reduce the supply of, and demand for, illicit drugs. The Department of Homeland Security is in a unique position to focus on market disruption through the strategic goals outlined in the Department's Secure Border Initiative, or SBI.

The Department of Homeland Security's Secure Border Initiative is a comprehensive approach to border control and enforcement through the integration of technology, infrastructure, communications, and command and control that is designed to disrupt and dismantle criminal organizations that violate the border by preventing and deterring cross-border crime including, but not limited to, illicit drugs and other contraband trafficking. Preventing the unlawful entry of individuals and goods from entering the United States, and working overseas to strengthen U.S. partnerships against illegal smuggling and immigration, is a priority for SBI.

SBI will provide a comprehensive, multi-year plan for more agents to patrol our borders, secure our ports of entry and enforce immigration laws as well as providing a comprehensive and systemic upgrading of the technology used in controlling the border, including increased manned aerial assets, expanded use of UAVs, and next-generation detection technology.

Through SBI, the Department of Homeland Security has developed the Border Enforcement Security Task Force concept, or BEST, and now has a practical vehicle to directly partner with State and local law enforcement officials to combat border violence and drug trafficking. BEST is charged with sharing information, developing priority targets and executing coordinated law enforcement operations designed to enhance border security, including interdicting drug traffickers. By establishing a new connectivity between the Department's intelligence community and law enforcement, BEST provides a focused response to intelligence-driven identified targets, such as criminal organizations that violate the border and will also improve the Department's overall effectiveness against a full range of other criminal activity along the border.

In conclusion, the Department of Homeland Security fully embraces its counter drug mission, and the Department will do its part to ensure the success of the Synthetic Drug Control Strategy by establishing productive working relationships with those DHS components and interagency partners tasked with combating the flow of illicit drugs into the United States.

Thank you and I look forward to answering your questions.

Mr. SOUDER. Mr. Rannazzissi.

STATEMENT OF JOSEPH RANNAZZISSI

Mr. RANNAZZISSI. Good morning, Chairman Souder, Ranking Member Cummings, Congresswoman Watson. On behalf of Administrator Karen P. Tandy, thank you for the opportunity to testify before you today regarding the Synthetic Drug Control Strategy. This strategy is a companion document to the President's National Drug Control Strategy.

The unique nature of synthetic drugs warrants a targeted response. DEA's efforts to address the synthetic drug problem have been ongoing for decades. The strategy provides DEA and contributing agencies a framework to continue our ongoing efforts and to chart new milestones to achieve domestic and international progress against methamphetamine and other synthetic drugs.

DEA worked with DOJ and ONDCP to implement a comprehensive innovative strategy to reduce availability of synthetic drugs and strengthen the international and domestic law enforcement mechanisms. The strategy focuses principally on methamphetamine and pharmaceutical control substances and incorporates many ongoing DEA programs that target these substances.

Methamphetamine is a unique synthetic drug. Its production requires no specialized skills, training, and its various recipes are readily available. Its precursor chemicals have historically been able to obtain and inexpensive to purchase.

The diversion of controlled pharmaceutical substances also continues to be a significant threat. Controlled pharmaceutical substances are diverted through several means, including illegal prescribing, theft, robbery, prescription forgery, doctor shopping, and, of course, the Internet.

The manufacture and use of methamphetamine is not a problem confined to the United States but has become prevalent in many regions of the world. The DEA through our law enforcement partnerships across the country and around the world has initiated successful investigations that have disrupted and dismantled significant methamphetamine trafficking organizations, particularly those targeting the United States. We have also taken an active role in fighting diversion of ephedrine and pseudoephedrine through both enforcement operations and international agreements. These initiatives resulted in substantial reduction in the amount of precursor chemicals entering the United States, but we have more to do internationally.

DEA has a key role toward achieving the administration's goals set forth in this strategy. Chief among our tasks would be the full implementation and enforcement of the Combat Methamphetamine Epidemic Act of 2005. Other domestic initiatives will include a national listing on the DEA Web site of the addresses of properties in which methamphetamine labs or chemical dump sites have been found. In addition, construction for a new clandestine lab training facility at the DEA academy will begin in the fall of 2006.

A key element of the strategy for combating methamphetamine is international cooperation, particularly in the area of precursor chemical control. Already, DEA and DOJ have facilitated and played a leadership role in several recent meetings of the inter-

national community. These meetings, such as the May 2006 National Methamphetamine Chemical Initiative Strategy Conference where the Attorney General announced several new anti-methamphetamine initiatives, have helped increase awareness around the world and resulted in agreements to monitor and track key precursor chemicals. Several nations, most notably Mexico, also have taken independent steps to control methamphetamine precursors.

Internet diversion of pharmaceutical controlled substances is especially difficult to investigate and overcome. Internet-based drug traffickers often mask their activities as those of legitimate on-line pharmacies. DEA's approach to pharmaceutical controlled substance abuse problems strives to balance two general policy concerns: Reducing the prescription drug abuse while not making the lawful acquisition of prescription drugs unduly cumbersome.

DEA is joined by the interagency community and responsible private sector entities in its effort to prevent pharmaceutical controlled drug abuse and diversion by collaborating with Internet service providers and companies, credit card and financial service companies, express mail carriers to target Internet-based drug traffickers, DEA is at the cutting edge of on-line drug investigations.

Although recent DEA operations are indicative of our ability to target the largest and most dangerous organizations, additional tools are needed. More can be done to eliminate Web sites that have telltale signs of their illicit nature, and steps can be taken to ensure that the legitimate doctor-patient relationship includes a face-to-face consultation.

DEA is fully committed in its role to meet the ambitious goals set forth in the Synthetic Drug Control Strategy.

Chairman Souder, Ranking Member Cummings, and Congresswoman Watson, I thank you again for the opportunity to testify, and will be happy to address any questions you may have. Thank you.

Mr. SOUDER. Thank you very much.

[The prepared statement of Mr. Rannazzissi follows:]

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Regarding

“The National Synthetic Drug Control Strategy”

Before The

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



June 16, 2006
2247 Rayburn House Office Building
Washington D.C.

INTRODUCTION

Chairman Souder, Ranking Member Cummings, and distinguished members of the House Government Reform Committee - Subcommittee on Criminal Justice, Drug Policy and Human Resources, on behalf of the Drug Enforcement Administration (DEA), I appreciate your invitation to testify today regarding DEA's efforts to support the Administration's *Synthetic Drug Control Strategy*.

OVERVIEW

The *President's National Drug Control Strategy* is the core document that describes the Administration's strategic approach for reducing illicit drug use in the United States. The Administration's *Synthetic Drug Control Strategy - A Focus on Methamphetamine and Prescription Drug Abuse*, is a companion document to the *President's National Drug Control Strategy*. While this and past Administrations have traditionally avoided promulgating drug control strategies focused on a single drug, or a single category of drugs, the unique nature of the illicit market for synthetic drugs warrants a targeted response as the illicit markets for synthetic drugs contain unique challenges and vulnerabilities. The *Synthetic Drug Control Strategy* also adheres to the format of the *President's National Drug Control Strategy* by setting goals, specifically for reducing synthetic drug use primarily of methamphetamine and non-medical prescription drug use. Another goal is that of reducing domestic methamphetamine laboratories.

DEA's efforts to address the synthetic drug problem have been ongoing literally for decades. Fast forwarding to recent history, the landscape has changed. Many of the drug trafficking organizations are of a poly-drug nature and present large quantities of methamphetamine to the domestic market. These organizations are mainly based internationally. Another phenomenon faced by the DEA has been the small toxic clandestine labs (STLs) that have been prevalent and abundant across the country. The *President's National Drug Control Strategy* and the *Synthetic Drug Control Strategy* have established a framework on which DEA will continue to perform its mission in support of those strategic goals. DEA has worked with ONDCP to implement a comprehensive strategy to reduce the availability of these substances, to strengthen international and domestic law enforcement mechanisms, and to be innovative in so doing. DEA is fully committed in its role to meet the ambitious goals set forth in the *Synthetic Drug Control Strategy* within the established time frame.

METHAMPHETAMINE

It is a unique synthetic drug in that its production requires no specialized skill or training, and its various recipes are readily available on the Internet. Its precursor chemicals also have historically been easy to obtain and inexpensive to purchase. These factors have contributed to methamphetamine's rapid sweep across our nation.

One of the primary threats posed by this drug is its addictive ability, which produces devastating effects on all of its victims. These victims are not only limited to those who choose to use this poison but others who become part of what could be considered methamphetamine's "collateral damage." These include the victims of methamphetamine-related crimes, innocent children whose homes have been turned into clandestine lab sites, law enforcement officers that work with the hazardous materials found at lab sites, and even the environment.

Methamphetamine also presents a dual threat to law enforcement authorities. They must simultaneously combat both the STLs and the "super labs," which are primarily controlled by Mexican drug trafficking organizations and are supplying the majority of the methamphetamine consumed in this country.

The critical element in combating each of these types of labs is the control of methamphetamine's primary precursor chemicals: ephedrine and pseudoephedrine.

Methamphetamine has left a mark on the United States, and it is increasingly becoming a problem in many parts of the world. The DEA, through our law enforcement partnerships across the country and around the world, has initiated successful investigations that have disrupted and dismantled significant methamphetamine trafficking organizations. We also have taken an active role in fighting the diversion of ephedrine and pseudoephedrine through both enforcement operations and international agreements. These initiatives have resulted in a substantial reduction in the amount of precursor chemicals entering the United States. However, we have seen a shift in the flow of these precursor chemicals to Mexico.

While law enforcement has had success in the fight against methamphetamine, much work remains to be done. Domestically, our law enforcement efforts have been aided by legislation passed by a number of states, which placed restrictions on the sale of methamphetamine's precursor chemicals. Through the reauthorization of the USA PATRIOT Act, specifically Title VII—Combat Methamphetamine Epidemic Act of 2005, additional tools were provided by Congress to enhance law enforcement efforts both domestically and internationally. DEA will avail itself of these new tools and ongoing initiatives to reduce the threat posed by methamphetamine to the United States and its partners around the world.

Domestic Situation

Methamphetamine found in the United States originates from two general sources controlled by two distinct groups. Most of the methamphetamine consumed in the United States is produced by Mexico-based and California-based Mexican traffickers. These drug trafficking organizations control "super labs" (a laboratory capable of producing 10 pounds or more of methamphetamine within a single production cycle) and produce the majority of methamphetamine available throughout the United States. Current drug lab seizure data suggests that roughly 80 percent of the methamphetamine used in the United States comes from these larger labs, which are increasingly found in Mexico.

These same Mexican criminal organizations control most wholesale, 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.

The second source for methamphetamine in this country comes from STLs, which produce relatively small amounts of methamphetamine and are not generally affiliated with major trafficking organizations. A precise breakdown is not available, but it is estimated that STLs are responsible for approximately 20 percent of the methamphetamine consumed in this country. 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 "recipes" are easily accessible over the Internet, that its ingredients are available in many over-the-counter cold medications and common household products found at retail stores and that the production of methamphetamine is a relatively simple process. These factors have helped serve as a catalyst for the spread of methamphetamine across the country.

Domestic Initiatives

With respect to DEA's domestic efforts, we are redirecting the focus of our Mobile Enforcement Teams (METs) and Clandestine Laboratory Enforcement Teams (CLETs). The significant reduction in domestic STLs will allow these teams to refocus their efforts at targeting Mexican methamphetamine trafficking organizations by tracing chemicals, finished methamphetamine, and proceeds to organizational leaders in the U.S. and Mexico, rather than merely locating and cleaning up labs. An additional focus of

these teams will be to identify and dismantle U.S.-based transportation and distribution cells. Other domestic initiatives will include a national listing on the DEA Web site of the addresses of properties in which methamphetamine labs or chemical dumpsites have been found. The registry will provide owners or renters with notice that a property may once have been used to produce methamphetamine and that there may be potential toxic hazards within the property.

In addition, a new clandestine lab training facility at the DEA Academy in Quantico, Virginia will be established in the fall of 2006. At this state-of-the-art facility, DEA will train U.S. and foreign law enforcement officials on the latest techniques in clandestine lab detection, enforcement, and safety.

DEA's longstanding enforcement efforts against methamphetamine include utilizing the Consolidated Priority Organization Targets (CPOTs) List, the Priority Target Organization (PTO) program, and the Organized Crime Drug Enforcement Task Force (OCDETF) program. The programs all provide assistance in identifying and targeting the most significant methamphetamine trafficking organizations, with the intent to disrupt and dismantle the organizations.

The FY 2006 CPOTs list has identified 7 of the 46 designated organizations as being engaged in methamphetamine trafficking. At the end of the second quarter of FY 2006, the DEA had 149 active PTO investigations linked to those 7 CPOTs, of which 28 were active PTO investigations with methamphetamine as the primary type of drug. Since the inception of the PTO program in 2001, the DEA has either disrupted or dismantled in excess of 460 PTOs, where methamphetamine was the primary drug involved.

To further coordinate and focus our methamphetamine and precursor chemical initiatives, the FY 2006 Department of Justice (DOJ) Appropriations Act directs the Attorney General to establish a Methamphetamine Task Force (MTF) within DEA. The purpose of the Task Force is to improve and target the Federal government's policies with respect to the production and trafficking of methamphetamine. The MTF is comprised of three DEA Special Agents, two Diversion Investigators (DIs), three attorneys, and one Program Analyst. These are veteran personnel with extensive experience and knowledge in the field who will collect and analyze investigative and intelligence information from numerous sources. Their analysis will focus on trends in chemical trafficking and manufacturing methods, changes in trafficking routes and patterns, and regional abuse and distribution patterns. They also will analyze and monitor foreign and domestic precursor sources and trafficking trends, as well as methods of financing. In addition, the MTF will be involved in tracking sources of chemicals and equipment as well as methods of procurement and clandestine laboratory cleanup issues. Another aspect of the MTF's duties will involve the proposal of various recommendations addressing issues that are identified from their analysis. These recommendations will be forwarded to the National Synthetic Drugs Interagency Working Group for review and action.

International Situation

The manufacture and use of methamphetamine is not a problem confined to the United States, but rather it is a drug that has spread to many regions of the world. In fact, the International Narcotics Control Board (INCB) noted in its 2005 report "Precursors and Chemicals Frequently Used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances" that illicit manufacture of methamphetamine is spreading throughout the world at an alarming rate. Specifically, the INCB indicates that the illicit manufacture of amphetamine-type stimulants (ATS)¹, in particular, methamphetamine, is spreading in North America, Southeast Asia, and increasingly, to other areas such as Africa, Eastern Europe, and Oceania. The report

¹ In Europe and Asia, the term "amphetamine-type stimulants" is used rather than a specific reference to methamphetamine. This term is also used by the United Nations. ATS generally refers to amphetamine, methamphetamine, and MDMA (Ecstasy), and its analogues.

further stated that the spread of methamphetamine is due to the simple manufacturing process and the availability of the required precursors.

International Initiatives

From DEA's perspective, international cooperation is the key in combating methamphetamine. Some of the most significant and successful international efforts to combat methamphetamine involve a series of enforcement initiatives worked jointly between law enforcement in the United States and Canada from the late 1990s into 2003. These enforcement initiatives, known as Operations MOUNTAIN EXPRESS I, II and III and Operation NORTHERN STAR, were principally responsible for the significant reduction in the amount of pseudoephedrine entering the United States for use in Mexican-controlled super labs. In turn, most of the super labs and the pseudoephedrine needed for them moved from the United States to Mexico.

The DEA is the lead agency in working with our Mexican counterparts to combat methamphetamine. Since 2001, the DEA has provided or sponsored training on numerous occasions for our Mexican counterparts in the areas of clandestine laboratories, chemical training, and related prosecutions. Training has been provided to officials who regulate precursor chemicals and pharmaceuticals at the state and Federal level within Mexico, as well as agents from the Agencia Federal de Investigaciones (AFI) and a number of prosecutors within the Mexican Organized Crime Unit (SIEDO). The combined numbers of students who have received training through these cooperative efforts exceed 450. In addition, the United States and Mexico have jointly obtained a commitment from 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.

Mexico has independently implemented several controls on pseudoephedrine in cooperation with industry, and is considering others. Those implemented now, or planned soon, include: (1) limiting retail sales to pharmacies; (2) limiting sale quantities to three boxes of 60 milligram or more combination pseudoephedrine products; and (3) distributors voluntarily agreeing to limit sales to customers with appropriate government registrations (pharmacies) and with legitimate commercial needs. Mexico also imposed recently a policy limiting imports of pseudoephedrine and ephedrine to manufacturers only. Wholesale distributors are barred from importing raw material pseudoephedrine and ephedrine, and importers are limited to shipments of no more than 3 metric tons at a time.

Very recently, Mexico began imposing import quotas tied to estimates of legitimate national needs, which are based on extrapolations from a large population sample. A study conducted by The Federal Commission for the Protection against Sanitary Risk (COFEPRIS) revealed that there is an excess of imports of pseudoephedrine products of approximately 60 to 100 metric tons. The DEA has been advised that it is the Government of Mexico's (GOM) intention to reduce pseudoephedrine and ephedrine importation permits to 70 tons, in total for 2006. These permits are to be split evenly among the Mexican-based pharmaceutical manufacturing companies. This is a significant reduction from the 2005 pseudoephedrine and ephedrine importation levels. Mexican officials have further advised that this 70-ton limit also applies to combination products containing pseudoephedrine and/or ephedrine.

An example of Mexico's interdiction efforts concerning pseudoephedrine occurred during December 2005, when approximately 3.2 metric tons (approximately 5.1 million pseudoephedrine combination tablets) of pseudoephedrine were seized by Mexican authorities in the Port of Manzanillo, Mexico. The tablets were concealed within a shipment of electric fans, which were packaged in approximately 1,260 boxes. During the follow-up joint investigation conducted by DEA and Hong Kong Customs and Excise Department, officials disclosed that the shipment originated in mainland China and transited one of the mainland China/Hong Kong border crossings before being subsequently loaded on a marine vessel en route to Mexico.

At the May 2006 National Methamphetamine and Chemicals Initiative (NMCI) Strategy Conference in Dallas, Attorney General Gonzales announced important new anti-methamphetamine domestic initiatives, as well as new partnerships between the U.S. and Mexico in fighting methamphetamine trafficking. Joined by Mexican Attorney General Daniel Cabeza De Vaca, Attorney General Gonzales unveiled DOJ-led initiatives aimed at addressing improved enforcement, increased law enforcement training, improved information-sharing, and increasing public awareness.

Among the U.S./Mexico partnership efforts is an agreement between DEA and the GOM to establish specialized methamphetamine enforcement teams on either side of the border. In Mexico, these teams will focus on investigating and targeting the most wanted Mexican methamphetamine drug trafficking organizations, while DEA-led efforts on the U.S. side will focus on the methamphetamine traffickers and organizations transporting and distributing the finished methamphetamine being produced in Mexico.

Other initiatives that are part of the U.S./Mexico partnership include:

- A new DEA and Customs and Border Protection Service effort to focus on ports of interest within the United States targeting suspicious cargo that is likely to be related to methamphetamine trafficking organizations;
- A Bi-national Law Enforcement Working Group that will focus on methamphetamine production and trafficking from both an enforcement and intelligence perspective;
- A DEA and Mexican National Conference for Information, Analysis and Planning in Order to Fight Crime (CENAPI) effort to further share intelligence information and continue to develop stronger working relationships. Such collaborative efforts will focus on investigating large-scale methamphetamine trafficking organizations that are operating in Mexico and the United States.
- A jointly developed DEA and Mexican police Most Wanted List of chemical and methamphetamine trafficking organizations that will focus bilateral law enforcement efforts on the biggest threats;
- An agreement between the DEA Office of Diversion Control and Mexico's chemical regulatory agency, COFEPRIS, to a personnel exchange in which chemical regulatory experts from within each agency will be embedded within the other's agency for a specific period to observe, learn best practices, and then implement joint strategies complimentary to both regulatory agencies;
- Eight DEA trucks used in clandestine lab enforcement operations that have been refurbished and donated to Mexico to be used by the above referenced specialized Mexican enforcement teams; and
- In conjunction with the Department of State's (DOS) Bureau for International Narcotics and Law Enforcement Affairs (INL), DEA will provide training for nearly 1,000 Mexican police officials to focus on a variety of investigative, enforcement, and regulatory methods related to methamphetamine trafficking.

Another important aspect of our international efforts to combat this drug has been the assignment of DIs to a number of our foreign offices. These DIs, through their knowledge of pharmaceuticals and chemicals, play a critical role in preventing the diversion of List I chemicals and pharmaceutical controlled substances. The DIs coordinate with foreign host country counterparts to establish effective systems of chemical controls and ensure customers in foreign countries receiving U.S. exports of pharmaceutically controlled substances are in fact legitimate companies.

Precursor Chemical Control Efforts

In addition to these efforts with Mexico, the DEA, operating under the auspices of Project Prism, hosted a meeting in February in Hong Kong for law enforcement and regulatory officials of producing countries of ephedrine/pseudoephedrine and 3-4 methylenedioxyphenyl-2-propanone (PMK). The objective of this meeting was to develop and enhance systems for voluntary cooperation in data collection and exchange in law enforcement channels to build a consensus towards exchange of information on pharmaceutical preparations containing ephedrine and pseudoephedrine, as well as bulk precursor chemicals. This was the first time that almost all of the countries that produce these chemicals and those countries affected by methamphetamine have sat down together to discuss this problem. While there were some differences of opinion as to the manner and channels in which information regarding the licit trade in these substances should be exchanged, it was important to bring precursor chemical producing nations and nations in which illicit drug manufacturing occurs together for candid discussions. The communication that occurred between countries attending the open forum meeting was encouraging. The DEA, in cooperation with the DOS, will continue discussions with all involved countries. The discussions will seek to determine the worldwide production of these chemicals, to further identify producers and distributors, to gain better insight as to what form (bulk versus tablets) the chemicals are manufactured and distributed at various stages, and to learn where the chemicals are destined.

The Hong Kong meeting also helped to lay a foundation for discussions and negotiations between concerned governments, which led to the passage of a resolution at the 49th Commission on Narcotic Drugs (the CND) in Vienna, Austria, in March of this year. The resolution, entitled "Strengthening Systems for Control of Precursor Chemicals Used in the Manufacture of Synthetic Drugs," involves the synthetic drug precursors previously mentioned, as well as preparations containing these substances and phenyl-2-propanone (P2P). The resolution calls on all nations who are signatories to the various United Nations' conventions dealing with drugs and precursor chemicals to provide to the INCB annual estimates of their legitimate requirements for these substances, and preparations containing these substances. The resolution also calls for nations to ensure that its imports of these substances are commensurate with their respective nation's legitimate needs and urges them to continue to provide to the INCB, subject to their national legislation and taking care not to impede legitimate international commerce, information on all shipments of these substances. The resolution further requests countries to permit the INCB to share the shipment information on these consignments with concerned law enforcement and regulatory authorities to prevent or interdict diverted shipments. While we consider this resolution an important first step, our ability to obtain additional information from the INCB is contingent upon nations providing the information requested pursuant to the resolution.

The DEA 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 7 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, DIs 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.

Combat Methamphetamine Epidemic Act of 2005

Internationally, the Combat Methamphetamine Epidemic Act of 2005 will expand the notice of importation to include all information known to the importer on the chain of distribution. If it is determined that an importer is refusing to cooperate in providing such information or DEA has concerns about the downstream customers, the DEA may issue an order prohibiting the importation of Scheduled Listed Chemical Products (SLCP). Further, the Act requires the DOS to identify the five largest exporting countries and the five largest importing countries with the highest diversion of SLCPs and provide an economic analysis of worldwide production as compared to legitimate demand.

Domestically, the Act provides effective new tools to use in the battle against methamphetamine. The ability of pseudoephedrine to be sold on the spot market will be effectively taken away. These transactions which were not regulated under current law will be treated as new imports or exports and, therefore, subject to 15 day advance notification during which DEA will verify the legitimacy of the transaction. In addition, DOJ has the authority to establish production and import quotas for ephedrine, pseudoephedrine, and phenylpropanolamine. These quotas will allow for the greater control of these precursors that are imported into the United States.

PHARMACEUTICAL CONTROLLED SUBSTANCES

The Administration's approach to the pharmaceutical controlled substance abuse problem strives to balance two general policy concerns. The first is to be aggressive in reducing prescription drug abuse. The second is to avoid overreaching and making the lawful acquisition of prescription drugs unduly cumbersome. As stated in the *Synthetic Drug Control Strategy*, the Administration is committed to balancing the need for prevention, education and enforcement with the need for legitimate access to pharmaceutical controlled substances.

DEA and DOJ are working to implement this aspect of the Strategy which is to stem the diversion of pharmaceutical controlled substances in the United States, while ensuring an uninterrupted supply for legitimate demands. Pharmaceutical controlled substances are diverted through several means, including illegal prescribing, theft, robbery, prescription forgery, doctor shopping, and the Internet.

The diversion of pharmaceutical controlled substances continues to be a significant challenge. Internet diversion of pharmaceutical controlled substances is especially difficult to investigate and overcome. Internet-based drug traffickers, most commonly selling pharmaceutical controlled substances or those marketed as such, often mask their activities as those of legitimate online pharmacies. The DEA Special Operations Division's Internet Investigation Unit coordinates Internet investigations and has been successful in the suspension of activities of numerous Internet pharmacies. The DEA will continue to bring forth legal action against doctors and pharmacies that illegally distribute pharmaceutical controlled substances via the Internet.

International Situation

A quick search on the Internet reveals thousands of sites offering pharmaceutical controlled substances for sale. Internet drug traffickers offer drugs for sale without a prescription, without benefit of a legitimate doctor-patient relationship, and at highly inflated prices. Recent DEA investigations involving Internet drug traffickers that use the façade of legitimate online pharmacies reveal these pharmaceutical controlled substances being sold at four to ten times the price offered by legitimate "brick and mortar" pharmacies.

Purchasing pharmaceuticals over the Internet exposes consumers to risks such as purchasing a product that is counterfeit, is improperly handled or stored, is contaminated, or is lacking any warnings or instructions for use. With few exceptions, the consumer has no idea of the content of the substances they are receiving. Internet drug traffickers who illegally offer pharmaceutical controlled substances through their websites frequently share characteristics, such as:

- Advertise that no prescription is necessary;
- Fail to participate in any insurance plan and require payment by credit card or cash on delivery;
- Offer a limited selection of medications for sale, mostly controlled substances and "lifestyle drugs;"
- Fail to request the name, address, and phone number of a current physician;

- Are willing to deliver drugs to a post office box or other location to avoid detection by authorities; and
- Deceptively and inaccurately advise about the law and why it is permissible to obtain pharmaceutical controlled substances from foreign countries via the Internet.

As part of the scheme, online "consultations" consisting of medical questionnaires filled out by an individual purport, yet fail, to create a legitimate doctor-patient relationship. A legitimate doctor-patient relationship generally includes a face-to face consultation, where a licensed physician can examine the physical symptoms reported by a patient before making a diagnosis and authorizing the purchase of a prescription medicine. Filling out a questionnaire, no matter how detailed, is no substitute for a legitimate doctor-patient relationship.

DEA's contention that no legitimate doctor-patient relationship exists during a transaction that involves only a questionnaire is shared by the medical profession. The Federation of State Medical Boards' (FSMB) policy on Internet prescribing affirms that the prescribing of medications by physicians based on an online medical questionnaire clearly fails to establish an acceptable standard of medical care. The American Medical Association (AMA) indicates that appropriate Internet prescribing involves a valid physician-patient relationship, including a physical examination (except in cases involving an on-call or cross-coverage situation, or where the prescription is made in consultation with another practitioner who supervises the patient's treatment). Further, the AMA supports action by state medical boards against physicians who fail to meet local standards of medical care when issuing prescriptions through Internet web sites.

The sale of these substances over the Internet is only one way that users illegally acquire pharmaceuticals. The DEA also investigates more traditional methods of diversion, including forged prescriptions, pharmacy robberies, unscrupulous doctors operating "pill mills" that essentially sell prescriptions and/or drugs after perfunctory or non-existent medical examinations, and pharmaceutical controlled substances that have been smuggled into the United States. A 2005 study by the National Center on Addiction and Substance Abuse (CASA) at Columbia University indicates the abuse of pharmaceutical controlled substances grew at a rate of twice that of marijuana, 5 times that of cocaine, and 60 times that of heroin between 1992 and 2003.

DEA Initiatives

Pharmaceuticals *can* be purchased safely and legally over the Internet but only if proper protocols are followed. Currently, there are only 12 DEA-registered pharmacies that have been included on a list of Verified Internet Pharmacy Practice Sites (VIPPS) compiled by the National Association of Boards of Pharmacy (NABP), an independent, non-profit organization of licensing boards. The NABP list identifies to the public those online pharmacy practice sites that are appropriately licensed, are legitimately operating via the Internet, and have successfully completed a rigorous criteria review and inspection. Most other Internet pharmaceutical controlled substance sales in the United States are legally suspect and potentially very dangerous.

The DEA focuses a significant amount of its resources on attacking PTOs, which are major drug supply and money laundering organizations operating at the international, national, regional, and local levels that have a significant impact on drug availability. Since October 2005, DEA has initiated over 236 investigations of online sales of controlled substances. In FY 2004, as a result of online pharmacy investigations, DEA seized over \$14.5 million in cash, bank accounts, property and computers—a 480 percent increase over 2003 (\$2.5 million). Two operations in particular warrant specific mention:

Operation CYBER CHASE

On April 19th and 20th, 2005, the DEA dismantled an international pharmaceutical controlled substance trafficking organization that supplied an estimated 100,000 "customers." As a result of this OCEDEF investigation, the leader of the organization (Akhil Bansal) and 25 co-conspirators were arrested in 4 countries. Their web of operations, however, touched many, many more.

We know that, since at least July 2003, the Bansal organization was responsible for the illegal distribution of 2.5 million dosage units of controlled substances per month to more than 100,000 "customers" without a medical evaluation by a physician. Bansal, an Indian national, supplied 8 separate drug organizations that together operated over 200 websites with pharmaceutical controlled substances he arranged to be smuggled from India. The success of this operation required the cooperation of numerous international, federal, state, and local law enforcement agencies.

Operation CYBERx

On September 21, 2005, a 15-month OCEDEF multi-agency Internet investigation concluded with the dismantlement of the Johar Saran drug trafficking organization based in Ft. Worth, Texas. The investigation resulted in 19 arrests including the leader of the organization, Johar Saran. This operation is the domestic bookend to Operation CYBER CHASE.

Saran and his co-conspirators were arrested for supplying pharmaceutical controlled substances directly to U.S. Internet customers without a medical examination by a physician. We believe that since August 2004, the Saran organization was responsible for the illegal distribution of 3.5 million dosage units of Schedule III-V controlled substances per month.

To date, this investigation has resulted in the seizure of \$16.8 million in assets-\$1 million in U.S. currency, \$5.5 million in bank accounts, \$8.6 million in real property, and \$1.7 million in jewelry. Immediate suspension orders against the DEA registrations of 21 pharmacies and 20 physicians were served in Texas, New York, Florida, Utah, Washington State, and Puerto Rico. The success of this operation was the result of cooperation by several other Federal and state law enforcement agencies.

Cooperation between the DEA and our international, federal, state, and local law enforcement partners is of particular importance when we are discussing Internet investigations. Traditional geographic lines of jurisdiction do not exist on the Internet, yet law enforcement must abide by such limits. This means that collaboration is a key component to successfully investigating and arresting those who are nothing more than drug dealers utilizing the anonymity of the Internet to ply their trade.

A federal interagency task force was established in early 2004 with the purpose of addressing Internet diversion of drugs and conducting public outreach on pharmaceutical issues, in general. Among other groups, DEA, Office of National Drug Control Policy (ONDCP), Immigration and Customs Enforcement (ICE), Customs and Border Patrol (CBP), and Food and Drug Administration have been represented at task force meetings. A major focus of this evolving task force has been to reach out to business leaders in key industry sectors that provide services used by Internet pharmaceutical trafficking groups, including providers of Internet services, express parcel delivery, and financial services.

The task force also has provided support to DEA through ICE and CBP special authorities. ICE and CBP have primary jurisdiction in the enforcement of trans-border smuggling laws and periodically conduct interdiction operations at international mail facilities to identify packages containing illicit pharmaceuticals. The task force meets quarterly and is currently evaluating options for establishing a single reporting point for businesses to report suspicious Internet pharmaceutical sites.

DEA coordinates this industry outreach on behalf of the task force. The purpose of this outreach has been threefold: (1) to raise awareness of the growing problem of pharmaceutical diversion via the Internet; (2) to elicit voluntary efforts to restrict legitimate business services from being used by illicit Internet drug traffickers; and (3) to identify potential sources of data maintained by the above businesses that may aid in targeting enforcement efforts against the largest illicit Internet drug trafficking organizations.

To successfully ply their trade, Internet drug traffickers must rely extensively on the commercial services of three principal business sectors: (1) providers of various Internet services, including web hosting, domain name registration, and search; (2) express package delivery companies; and (3) financial services companies, including major credit card companies and third party payment service providers. The DEA has reached out to each of these sectors and is working to educate and facilitate their assistance in shutting down Internet drug trafficking operations.

Several interagency meetings have been held with senior managers and legal counsel from leading Internet, parcel carrier, and financial services companies. DEA is following up these meetings directly with key companies to further develop efforts to combat the diversion of pharmaceuticals via the Internet. These meetings provide an opportunity for government and the private sector to reach a better understanding of relevant federal laws and explore areas of potential cooperation and voluntary industry action to curb the expanding illicit sale of pharmaceuticals over the Internet.

DEA Field Offices have also taken action against this threat. DIs conduct on-site licensing inspections to ensure that the pharmacy is aware of its responsibilities under the law. New pharmacy applicants or those seeking a renewal through on-line procedures are now linked to the April 2001 Federal Registrant Guidance Document regarding "Dispensing and Purchasing Controlled Substances over the Internet." A pop up link, titled "Retail Pharmacy Advisory," takes the applicant to the aforementioned Federal Register notice outlining important information for prescribers, pharmacists, and law enforcement officials.

During the CYBERx investigation, the DEA discovered that the main suppliers were legitimate DEA registrants. While DEA didn't discover any criminal negligence in this case, we did implement the Internet Distributor Initiative to increase awareness of DEA registrants regarding their obligations and possible role in the illegal distribution of pharmaceuticals via the Internet. Based on these meetings, the distributors voluntarily reviewed their customer base and apprised DEA of the termination of business with over 100 known or suspected illegitimate Internet drug trafficking organizations. An analysis of these pharmacies' buying patterns from January - September 2005 revealed over 60 million dosage units of controlled substances had been purchased.

Because of this initiative, many illegal Internet pharmaceutical sites are now unable to purchase large quantities of controlled substances for illegal sale domestically. While this is an effective approach to go after some domestic sources of illegal pharmaceuticals supplying the Internet, this will not affect foreign sources of pharmaceuticals. The global nature of the Internet adds to this challenge, as many substances which are controlled in the United States are not controlled elsewhere. Therefore, offering these substances for sale on line is not illegal, per se.

As a consequence of these and other initiatives, DEA is able to effectively monitor both the supply and dispensing sides of the domestic Internet drug trafficking problem. The communication between the DEA and the distributors continues to increase. An example of increased cooperation is the fact that distributors are notifying DEA of potential targets, unusual purchasing patterns, and queries from the potential illegitimate Internet pharmacies who have been effectively cut off from supplies by this initiative.

Although no special DEA registration is currently required to market controlled substances online, the tangible aspects of manufacturing, distributing, prescribing, and dispensing pharmaceutical controlled substances remain squarely under the jurisdiction of the Controlled Substances Act. Any legitimate transaction over the Internet must be in compliance with these existing laws. Additional clarification of the roles and responsibilities for professionals seeking to use the Internet to meet the needs of clients would not only allow us to more readily identify legitimate online pharmacies and persons operating and promoting them, but it would also assist in gathering information pointing to abuse patterns. Such clarification would also help us investigate drug traffickers hiding behind the façade of an otherwise legitimate practice.

Additionally, there exists no statutory definition of a valid "doctor/patient" relationship, and the penalties associated with the illegal sale of Schedule III-V substances are not as significant as may be warranted. This does not mean, however, that Internet drug traffickers can operate freely, as demonstrated by Operations CYBERx and CYBER CHASE.

The DEA will continue to promote collaborative actions and use our existing authority to investigate and arrest individuals illegally selling controlled substances. The increasing support we receive from key sectors of the Internet-related business community is essential to turning the tide in this critical area of drug trafficking and abuse. The DEA is committed to developing this relationship even further.

DEA'S PREVENTION AND EDUCATION EFFORTS

In an effort to provide further information to America's youth about the dangers of methamphetamine, the DEA developed and launched its 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.

In addition to our investigative efforts aimed to shut down illegal drug sales over the Internet, DEA is working with the state authorities and representatives of the pharmacy and medical communities to disseminate information regarding activities that can legally be conducted via the Internet

OTHER SYNTHETICS

DEA continues to act judiciously with respect to all synthetic drugs including, among others, fentanyl, MDMA, GHB and LSD. DEA has reacted swiftly to recent overdose events stemming from fentanyl-related consumption. Fentanyl is the drug most often presented for illicit sale as heroin and is 30 to 50 times as potent as heroin. It has recently appeared across the country in some cities and resulted in overdoses and fatalities. Multiple investigations have been opened in an effort to disrupt and eliminate this synthetic threat to our communities. Ultimately, it is the goal to dismantle either organizations or independent groups that are producing such dangerous substances and to destroy the source labs. DEA's regulatory section has initiated action to commence the regulation of key fentanyl precursor chemicals, including a starting material known as 1-phenethyl-4-piperidone (NPP) and an intermediate precursor chemical known as 4-anilino-N-phenethyl-piperidone (ANPP).

CONCLUSION

The DEA continues to fight synthetic drugs on all fronts. The *Synthetics Drug Control Strategy* provides DEA and contributing agencies a framework to continue the ongoing efforts and chart new strategies to achieve domestic and international progress against methamphetamine and other synthetic drug trafficking and abuse. A concerted organizational attack is the focus of our effort to counter drug traffickers

utilizing the Internet to facilitate their illicit trade. DEA's core competency, the disruption and dismantlement of drug trafficking organizations impacting the United States, is an integral component to *Synthetics Drug Control Strategy*.

Based on the international nature of the threat that methamphetamine and other synthetic drugs pose, cooperative efforts among nations become not just important—but vital-- in combating this menace. For methamphetamine, international precursor chemical control is critical to DEA's responsibilities in helping to achieve the Administration's ambitious goals set forth in the Strategy.

Thank you for the opportunity to appear before you today to discuss this important issue. I will be happy to answer any questions that you may have.

Mr. SOUDER. Dr. Young.

STATEMENT OF DR. DON YOUNG

Dr. YOUNG. Good morning, Mr. Chairman, members of the subcommittee. I appreciate the opportunity to discuss the efforts of the Department of Health and Human Services in support of the administration's Synthetic Drug Control Strategy focused on methamphetamine and prescription drug abuse.

I am pleased to be here to talk about the HHS contribution to the administration's coordinated strategy for combating the problems of methamphetamine abuse. The synthetic strategy was released June 1st this year, although HHS has been working with its Federal partners to develop the national synthetic drug's action plan since October 2004.

The synthetic's strategy sets a goal of reducing methamphetamine abuse over 3 years, a 15 percent reduction in the abuse or nonmedical use of prescription drugs over 3 years, and a 25 percent reduction in domestic methamphetamine laboratory seizures over 3 years. Much of the synthetic strategy is devoted to methamphetamine abuse. Methamphetamine is associated with serious health conditions, including memory loss, aggression, psychotic behavior, and potential heart and brain damage.

HHS is engaged on these issues through a number of its agencies. HHS brings a wide array of resources to this issue. The HHS fiscal year 2007 budget provides \$41.6 million for HHS methamphetamine targeted treatment and prevention research and a dedicated \$25 million for methamphetamine treatment services within the access to recovery program. The access to recovery program is a voucher-based program intended to expand consumer choice and access to effective substance abuse treatment and recovery support services. The Substance Abuse and Mental Health Services Administration and the Administration for Children and Families work together to provide training, technical assistance, information, and resources to local, State, and tribal agencies to improve systems and practice for families with substance abuse use disorders who are involved in the child welfare and family judicial systems.

One of the key components of meth is a commonly used pharmaceutical product, pseudoephedrine. Pharmaceutical products containing pseudoephedrine, either alone or in combination with other drugs, are used extensively by the general public to treat the symptoms of upper respiratory tract infections and allergic rhinitis.

In carrying out our strategy to end methamphetamine abuse, we must balance the legitimate health needs of consumers to access to medicines against the urgent needs of law enforcement to confront a serious drug problem. We believe that the U.S.A. Patriot Act recently enacted and signed into law achieves this balance. It restricts the OTC sales of pseudoephedrine, ephedrine, and phenylpropanolamine, but also enables individuals to buy sufficient quantities for legitimate medical use. By working together in a coordinated effective way, we can be successful in achieving the goals set out by the synthetic's strategy. By drawing on the resources my colleagues and I are discussing with you today, we can be success-

ful. Thank you for your time. And I would be pleased to respond to any questions.

[The prepared statement of Dr. Young follows:]



Testimony
Before the Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
United States House of Representatives

**The Administration's Synthetic Drug
Control Strategy: HHS Efforts to
Combat Methamphetamine and
Prescription Drug Abuse**

Statement of

Donald A. Young, M.D.

*Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services*



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Good morning, Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to discuss the efforts of the Department of Health and Human Services (HHS) in support of the Administration's *Synthetic Drug Control Strategy: A Focus on Methamphetamine and Prescription Drug Abuse (Synthetics Strategy)*. The *Synthetics Strategy* represents our combined efforts with the Office of National Drug Control Policy (ONDCP) and the Department of Justice (DOJ), although HHS has long been working on the prevention and treatment of methamphetamine abuse. I am pleased to be here to talk about the Administration's coordinated strategy for combating the problem of methamphetamine abuse and the abuse of prescription drugs.

The *Synthetics Strategy* was released on June 1 of this year, though HHS has been working with its Federal partners to develop the *National Synthetic Drugs Action Plan* since October 2004. With regard to the *Synthetics Strategy*, HHS served as one of three co-chairs to the Synthetic Drug Interagency Workgroup as well as co-chairing four of the five subgroups that helped develop the strategy. These five subgroups were:

- State and Local Support, co-chaired by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA);
- Foreign Pseudoephedrine, co-chaired by the Food and Drug Administration (FDA) and DOJ;
- Online Diversion, co-chaired by FDA and DEA;
- Data and Research, co-chaired by the Office of the Assistant Secretary for Planning and Evaluation at HHS and ONDCP; and
- Laboratory Remediation.

Through these subgroups and the interagency review process, HHS worked to ensure that the *Synthetics Strategy* was built on meaningful, achievable goals and provides a strategy that addresses both supply and demand reduction.

HHS Efforts

As you know, HHS is engaged on these issues through a number of its agencies. For instance, SAMHSA and the National Institute on Drug Abuse (NIDA) at the National Institutes of Health conduct extensive work on drug prevention, treatment, and associated research.

Synthetics Strategy

The *Synthetics Strategy* sets a goal of reducing methamphetamine abuse over three years; a 15% reduction in the abuse, or non-medical use, of prescription drugs over three years; and a 25% reduction in domestic methamphetamine laboratory seizures over three years.

HHS supports several of the data systems that will be used to evaluate the overall success of the Administration's *Synthetics Strategy*. They include: SAMHSA's National Survey on Drug Use and Health (NSDUH -- formerly known as the National Household Survey on Drug Abuse) and Drug Abuse Warning Network (DAWN); and the NIDA-supported Monitoring the Future (MTF) study. Data from these systems will be used to assess the following trends:

1. The number of past-year initiates in the 12-17 and 18-25 age ranges for methamphetamine (NSDUH)
2. The number of past-year initiates in the 12-17 and 18-25 age ranges for prescription drugs (NSDUH)
3. The number of emergency room admissions related to methamphetamine (DAWN)

4. The number of emergency room admissions related to prescription drug abuse (DAWN)
5. The average age of initiation for methamphetamine (NSDUH)
6. The average age of initiation for prescription drug abuse (NSDUH)
7. The percentage of youth who report perceived risk associated with both methamphetamine and prescription drug abuse (MTF)

Scope of the Problem

Much of the *Synthetics Strategy* is devoted to methamphetamine abuse. Methamphetamine (“meth”) is associated with serious health conditions, including memory loss, aggression, psychotic behavior, and potential heart and brain damage. Nearly 12 million people 12 years of age and older have abused methamphetamine in their lifetime, 1.4 million have abused meth in the past year, and nearly 600,000 have abused meth in the past-month, according to the NSDUH for 2004.

Estimates from DAWN indicate that drug-related emergency department visits involving amphetamines/methamphetamine increased to 102,843 in 2004. Also of great concern are findings from NIDA’s Community Epidemiology Work Group (CEWG), which monitors drug abuse problems in sentinel areas across the Nation. Moreover, according to the SAMHSA’s Treatment Episode Data Set, methamphetamine/amphetamine treatment admissions increased nationally from 1993 to 2003, from 14 to 57 admissions per 100,000 in the population ages 12 and older. A total of 18 States experienced methamphetamine/ amphetamine treatment rates higher than the national average in 2003. The proportion of drug treatment admissions for meth and other stimulants increased from 2% to 7% between 1993 and 2003.

Overview of HHS Strategy and Programs

HHS brings a wide array of resources to this issue. The HHS Fiscal Year 2007 Budget provides \$41.6 million for HHS methamphetamine-targeted treatment and prevention research and a dedicated \$25 million for methamphetamine treatment services within the Access to Recovery program, administered by SAMHSA.

Treatment and prevention initiatives administered by HHS are critically important elements of the *Synthetics Strategy*. In spring 2006, SAMHSA held two regional meetings with States on methamphetamine issues. The summits were specifically designed for those State agency staff involved in developing, regulating, and funding methamphetamine treatment.

SAMHSA’s Access to Recovery (ATR) program is a voucher-based program intended to expand consumer choice and access to effective substance abuse treatment and recovery support services, including faith-based providers. In August of 2004, SAMHSA awarded grants to 14 States and one tribal organization, including grants to Tennessee (\$5.9 million) and Wyoming (\$979,000) that focus specifically on meth addiction. It is estimated that this cohort of grantees will serve approximately 125,000 individuals over the three-year life of the grants. The President’s FY 2007 budget supports continuation of the ATR program at \$98 million, of which \$25 million is for a stand-alone voucher program for meth-specific treatment services. The ATR Methamphetamine voucher program will fund approximately 10 grants at \$2,475,000 each. The

program will limit eligible applicants to those States whose epidemiological data and treatment data indicate high methamphetamine prevalence and treatment prevalence.

Moreover, SAMHSA announced 11 new, three-year grants to provide treatment for methamphetamine abuse and other emerging drugs for adults residing in rural communities. These grants total \$5.4 million for the first year and approximately \$16.2 million for all three years.

To help better serve people with substance abuse disorders, a partnership exists between SAMHSA and NIH. Their common goal is to more rapidly deliver research-based practices to the communities that provide services.

NIDA continues to support research to develop effective drug abuse prevention programs. NIDA funding of meth-related research increased more than 150% from 2000-2005, from about \$15 million to more than \$40 million. In 2003, NIDA revised its *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*, which presents updated research-based prevention principles, an overview of program planning, and critical first steps for those learning about prevention. Because the goal of drug abuse prevention efforts is to prevent the initiation of drug use, most of these prevention efforts are not targeted toward any specific drug. However, recent results also demonstrate that these universal prevention programs can be effective at reducing methamphetamine abuse specifically.

In FY 2004, SAMHSA's Center for Substance Abuse Prevention (CSAP) awarded \$3.9 million to 9 grantees to support programs focused on methamphetamine, including a sole source grant to Iowa; in FY 2005, CSAP awarded an additional \$16.2 million over three years to 11 grantees. In FY 2006, CSAP expects to award approximately 9-11 new grants for a total of \$3.3 million to support methamphetamine prevention programs. In addition to these methamphetamine-specific programs, CSAP also supports a major initiative (through the Strategic Prevention Framework State Incentive Grant program) in which grantees conduct epidemiological surveys to determine the actual substance abuse prevention needs in their geographic areas. Eighty-five percent of the total award is to be used by sub-recipients to direct funding to the areas of greatest need, which could include methamphetamine prevention.

In order to improve the ability of substance abuse and child welfare agencies to work together to meet families' needs, SAMHSA and the Administration for Children and Families (ACF) have jointly created and funded the National Center on Substance Abuse and Child Welfare (NCSACW) to provide training, technical assistance, information, and resources to local, State and tribal agencies to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems. The Center's staff has developed a methamphetamine resource list, responded to numerous requests regarding methamphetamine and child welfare issues and provided conference workshop presentations and teleconferences on the impact of methamphetamine on child welfare practice.

In May 2006, ACF, in collaboration with SAMHSA's Center for Substance Abuse Treatment, convened a national conference on "Methamphetamine: The Child Welfare Impact and Response." This conference brought together more than 300 State and local child welfare,

substance abuse, and child care agency representatives to discuss the specific issues with which professionals and agencies are dealing related to child welfare and meth. The conference provided a forum to share the successes and challenges that have been faced by different States in addressing their meth issue, as well as highlighting some promising practices that have been developed. An additional goal of this meeting was to encourage collaboration between agencies within each State to address the issue and also to provide inspiration and ideas for ongoing work.

The FDA has been actively engaged in efforts to address the problems surrounding methamphetamine abuse. FDA has worked directly with ONDCP and DEA on issues relevant to the availability of pseudoephedrine and ephedrine, precursors used to manufacture methamphetamine.

One of the key components of meth is a commonly used pharmaceutical product, pseudoephedrine. Pseudoephedrine is an approved over-the-counter (OTC), as well as prescription, medication indicated for use as a nasal decongestant. Pharmaceutical products containing pseudoephedrine, either alone or in combination with other drugs, are used extensively by the general public to treat the symptoms of upper respiratory track infections and allergic rhinitis. FDA estimates that in 2004, approximately 700 million doses of pseudoephedrine products (both OTC and prescription) were sold, and another 11.5 billion doses of pseudoephedrine in combination with another drug ingredient, both OTC and prescription, were sold. In carrying out our strategy to end methamphetamine abuse, we must balance the legitimate health needs of consumers to access medicines against the urgent needs of law enforcement to confront a serious drug problem. We believe that the USA Patriot Act, recently enacted and signed into law, achieves this balance. It restricts the OTC sale of pseudoephedrine, ephedrine, and phenylpropanolamine, but also enables individuals to buy sufficient quantities for legitimate medical use.

While DEA is responsible for enforcement of the provisions of the USA Patriot Act, FDA will work with manufacturers to assist in their efforts to reduce pseudoephedrine abuse. There are efforts underway by the pharmaceutical industry to replace pseudoephedrine in OTC medications, and there are currently other OTC medications on the market for cold and allergy symptoms that do not contain pseudoephedrine. Some manufacturers have stated that they intend to substitute phenylephrine in their OTC products that currently contain pseudoephedrine.

Conclusion

By working together in a coordinated, effective way, we can achieve success in achieving the goals set out in the *Synthetics Strategy*. By drawing on the resources my colleagues and I are discussing today, we can be successful. Thank you for your time. I would be pleased to respond to any questions.

Mr. SOUDER. I thank each of you for your testimony. And the button on the microphones are counter-intuitive. If it is up, it is on; if it is down, it is not.

Let me make a couple of additional comments with my frustration. That, Mr. Burns, I hope ONDCP understood a very subtle message that Congress gave this week. And this hearing today is going to focus mostly on meth, most likely. You will see this committee increasingly move as we hopefully start to turn some corner on meth, at least get an aggressive strategy in every agency more toward over-the-counter drugs which clearly is a steady and increasing problem in the United States. We have had multiple hearings on OxyContin over the years, but we focused on meth in this cycle because at the local level, that is what we are hearing constantly. The idea to battle meth didn't start in Congress, even though this committee held its first hearings probably 7 years ago on this. It is being something that is demanded at the grassroots level. All you have to do is turn on your TV set in any market in almost every single State now, but certainly in about 40 States, it is still coming in to the east coast, and that will be the major story, and that demand came on the politicians.

I have been a strong supporter of the National Ad Campaign. Last, there has been a concern that the National Ad Campaign has been dropping in its funding by the director and by others. I said that if the National Ad Campaign started to address some of it, I have not opposed the marijuana initiative, but some of it focused on meth, we could sustain the support in Congress. We brought a resolution to the floor last year and it was increased by \$30 million over the President's request if it was used on meth. That was ignored. This week, the Appropriations Committee reduced it yet further to where the National Ad Campaign is at risk. And as you full well know, in the Senate, they have not been as enthusiastic with the ad campaign as the House. It got reduced to \$100 million. The administration came over and asked multiple Members of Congress to introduce it. They talked to our leadership. Not a single Member of Congress was willing to go to the floor to defend the position of the National Ad Campaign. Not one single Member of either party because of the lack of responsiveness of this administration on meth. And if that message doesn't permeate, there will be no National Ad Campaign. That is just, that is not a threat, it is a promise. That there has to be more responsiveness and an understanding of what is happening.

Second, this is the second year in a row where you have come in proposing to zero out what is the primary funding of our drug task forces around the United States on meth. You work with State and local law enforcement, and you know the intensity of this. On the HIDTA question, this year it wasn't a zeroing out of the HIDTA. I have asked repeatedly, what don't you like about HIDTAs? Which one? And the only answer I have gotten steadily is: The proliferation of HIDTAs has occurred in the United States denigrating the original mission of the HIDTAs, which was high intensity. Well, what is the proliferation of the HIDTAs? Where are those proliferations? Well, that would be the Missouri HIDTA, which is a meth HIDTA; that would be in Iowa, which is a meth HIDTA; that would be the Rocky Mountain HIDTA, which is a

meth HIDTA; that would be the Dallas HIDTA, which is focused more and more on meth. In other words, the administration's proposal indirectly, though it has never said directly, it has said to proliferation, all of the new HIDTAs were meth HIDTAs.

So that to come forward with the strategy at the same time while you are proposing to gut many of the things that are in it, we just don't see this reconciliation.

Now, let me be honest. We were looking for a few more specific things than today in your testimony what you chose to highlight was the endangered children program, which is a great program and should be expanded, and conferences. We have meth conferences going through our ears in the United States. Any person who is in the field who can't go to a meth conference has—I don't know where they have been. There are conferences all over the place. What we need are specifics. Quite frankly, the DEA presentation today—and DEA's been the only agency that has been very aggressive on this, as opposed to somewhat aggressive on this—had more details than the plan, which is astounding.

Here we wait and wait and wait, and we get a plan, and the testimony that comes forward from one of the agencies is more detailed with specifics and somehow to address how we are going to deal with this on the Internet.

We all know we are going to control the mom and pop labs, no thanks to the Federal Government. The State governments are already doing it, and now we are going to finish the rest of the States by October 1st. We are going to reduce the mom and pop labs. You are going to reach your reduction figures, which are—they are going to be done because of what other people already did. Not necessarily on synthetic drugs overall. Over-the-counter is going to be tougher. But the mom-and-pop labs are going to reach that. But it is going to move to the Internet. There were a number of things in DEA testimony to try to address that.

Now, let me ask Mr. Dhillon, and I am not holding you accountable, because you are new in the post. And we are glad to have you there, and we have worked together on the Homeland Security Committee, of which I am a senior member. Why would the Department of Homeland Security not have been more mentioned or—how do you see this integrated? For example, I am making some suggestion to you and I would like to hear some of your comments back.

DEA, Mr. Rannazzissi made some comments about how they are looking at this. Clearly, one of the things, since you are both in charge at Homeland Security of ICE, you are in charge of Coast Guard, and you are in charge of CBP, three of the major agencies with this; DEA would be a fourth that at the Federal level provides actual ground troops. Is there an awareness in the agency? Do you see an awareness of the agency to look at the data that you are picking up? For example, you are going to have the data of whether meth from Mexico is coming across from Laredo or the west. Are you going to look at that data and work directly with DEA or the intelligence agencies? Is ICE going to connect up with DEA? How do you propose to do that? Is Coast Guard going to do that? Are you going to look at—because as we shut down the mom-and-mop

labs, both the Internet and the border are going to become the places where crystal meth is coming in behind.

We see that in Oregon already, we see it in Oklahoma. The States that did the pseudoephedrine control laws have already seen the switch to crystal meth. It is coming your way. It is coming through all of your zone. Are you going to try to separate out the data here? Are you going to work with it? Are you going to work with particular strategies? Are your agents? I am less concerned about a national conference than basically making sure that CBP and ICE understand that the meth pressure is going to come at yours, and you are watching for that and the patterns.

Mr. DHILLON. Chairman Souder, I believe that it is my responsibility as the Director of the Office Counter-Narcotics Enforcement to obtain that information, that data that you are talking about, and to ensure that the counter-narcotics-related components within the Department have that data and are appropriately focused on the meth threat.

As you have pointed out, and I think as everyone has acknowledged, methamphetamine is now largely moving across the borders, which makes it a Department of Homeland Security issue and, as far as I am concerned, a Department of Homeland Security priority in the counter-narcotics realm.

So the answer to your question is, yes, we will be looking at the data and we will be ensuring that the counter-narcotics-related components that you have mentioned have that data, and will be emphasizing the importance of including methamphetamine interdiction in the overall counter-narcotics strategy.

Mr. SOUDER. Dr. Young, one of my concerns, and I have talked to Director Curry about this as well, is that methamphetamine—one of the pattern differences is it tends to be, less so for crystal meth, but where it has been so far in the mom-and-pop labs, tends to be in the most rural areas of America, that where the drug treatment programs are, in fact, the least sophisticated.

Much of the type of approaches that HHS recommends are fairly complicated. And when Director Curry came into my district, the only group that was implementing it was in Fort Wayne where they have only had basically three or four cases of meth. One of the outlying mid-sized cities had been at a conference where that subject was discussed, and the rural area that was hardest hit with meth had the least, the most underpaid, the just out of school trainee who hadn't even heard of the concept.

Is there an understanding in HHS of these two variables? One is, is that this, the one type of phenomena tends to be a rural phenomena often coming out of where there are national forest areas or more rural places because of the smell of labs, they hide out there.

And then the second, as the crystal meth comes in, you have a different type of pressure, and that may become a more urban pressure although some of the rural areas may pick it up. Is there that type of sophistication and analysis internally?

And then, second, the strategy suggested that there was a difference of opinion suggesting that meth treatment does work, which there are a lot of conflicting opinions on how and how well. But what are you doing to overcome that and to target it? Are you

saying that the same treatment programs work for meth that work elsewhere? Are they particular treatment programs with variations? And could you address some of those type of questions?

Dr. YOUNG. I did not. I would imagine that Mr. Curry gave you a response to that as well.

The whole problem of health care delivery and substance abuse treatment as a subset of health care delivery in rural areas is an extremely difficult one. It is one both of resources, as you point out, and how to get resources in adequate amounts, but it is also manpower and skilled people, which you pointed out. You can attempt to deal with some of that through other kind of social programs, transportation support, but that has limited value as well.

So I think, yes, there is a realization about that in the Department. That realization goes far beyond simply methamphetamines to other drugs but to other health care services in rural areas, very different set of problems than in the inner city, although the inner city has problems as well. They are just a very different kind. So, yes, I think we are aware of it.

On the issue of treatment, it is very clear treatment does work. Treatment is very difficult. It is very difficult for any substance abuse problem, and that includes methamphetamines. But when one looks at treatment one also has to look at treatment in the context of the individual, the family, their life-style, where they live. If you treat an individual and they go back to the environment that they were living in prior to treatment, their chance of recidivism is much greater. This has to be an integrated approach.

As I mentioned in my testimony, the problem that ACF is dealing with and families, this is a family problem, an individual problem, a medical problem, a social problem. It has to all be approached together. It cannot be approached from a single facet.

Mr. SOUDER. Thank you.

Mr. Cummings.

Mr. CUMMINGS. I want to pick up where we left off there. One of the things about meth is that it has a very traumatic direct effect upon families and particularly children. Can you tell me about any new programs coming up that will help these children?

Let me tell you where I am going. I have lived long enough and seen enough in Baltimore to now see generational cycles of drug use. As a lawyer prior to coming to Congress, I had an opportunity to represent the children and sometimes the grandchildren of people that I represented when I first came to practice with regard to drug crime. So you see these generational cycles. So I am wondering what are we doing to try to stop—and any of you who have anything else to add, I am curious—to stop the generational cycles of this continuing to go on.

Dr. YOUNG. Your question is direct to the prevention side or to the treatment side or both?

Mr. CUMMINGS. You can talk about—I am talking about when these kids are found in these houses, these labs, there are a lot of issues; foster care problems arise. As we have traveled across the country, so many local officials have said that we have been overburdened with regard to kid issues.

I am just wondering—you can talk about it any kind of way you want. I am trying to figure out—we have a major agency here that

deals with health; and I am just wondering exactly what you all are doing about it, if anything.

Dr. YOUNG. There are various parts of the Department, but in the issue of the children it would be the Agency for Children and Families that are involved. Part of what we are doing is making sure we are coordinating across the new research, the research which is showing more treatment patterns and what works best with the service delivery. So one is the integration and the coordination and the sharing of information from those people who are doing research on what works, whether it is prevention or treatment, and those that are running the programs. Much of that is done with grants or it can be done through the access to recovery program.

There will be different approaches taken in different communities. There is no one single one way to do it or one single program to do it. So there is discretion given to the communities in how they carry out the individual prevention or treatment programs and education. But under all circumstances, though, we do everything we can to bring the newest state of the knowledge to those folks.

Mr. CUMMINGS. Mr. Burns, I want to go to the Synthetic Drug Control Strategy.

Dr. Young, by the way, I will get back to you. I think I want a little bit more information. Perhaps you can do it in writing, but I was not satisfied with your answer. But let's go on. We have a limited amount of time.

Can you explain to me, Mr. Burns, exactly—and I know we are going to be talking later at another hearing about treatment, but help me understand how only three and a half pages of the Synthetic Drug Control Strategy was devoted to prevention and treatment. What happened?

Mr. BURNS. Well, Mr. Cummings, the strategy is balanced. There are no monumental breakthroughs with respect to treatment protocol.

I think one of the things that we all agree upon now, you mentioned in your opening statement that people suffering from the disease of addiction to methamphetamines can be treated. There are successes every day across the country. The intent of the strategy was not to equal the pages so that 11 pages were for treatment and prevention, 11 for supply reduction. It was a strategy that is comprehensive with respect to what we are facing today.

And in that respect let me say this—

Mr. CUMMINGS. Since we have all this balance here, why don't you just specifically tell me what the prevention and treatment strategies are? Go ahead. I am listening.

You said—I said three and a half pages. You said, well, those three and a half pages out of 80 something is balanced. Fine. Tell me what they are. What do we have new here?

The people who are looking at this right now who are sitting in their rural homes and the mayors and city council people are trying to figure out, to have some hope that they can deal with a problem that is devastating their communities, and I have one of the top drug people in the Nation, just a wonderful expert, and they

are looking to hear from your lips. They want to get past the three and a half pages. So let's talk about the balance. Talk to me.

Mr. BURNS. The response would be a \$12.7 billion request from this President and this administration, which is \$80 million more than Congress enacted last year. So that is a start.

The second thing I would say——

Mr. SOUDER. On meth?

Mr. BURNS. Overall Federal drug control budget. We have to start somewhere. We have to start with the premise that the commitment from this administration against illicit drug use in this country is larger than it has ever been. With respect to treatment, some \$4.5 billion requested by the President in 2007.

Let me address the question about mayors and people sitting in cities. This administration and the Director of the Office of National Drug Control Policy for 2 years now has sent me and other deputies and a large amount of staff to 25 plus major cities in this country, including Baltimore, including Sacramento, including Indianapolis; and we have sat down with mayors and chiefs of staffs and police chiefs and treatment and prevention folks. We have talked about, do you have community coalitions? Do you have drug courts? What is happening with Byrne grant money? Is there a balance in your particular city?

For the first time, we have had a national discussion about how Federal, State and local moneys are applied against a threat in a particular city.

Mr. CUMMINGS. Let's put a pin right in that. When you meet with all these wonderful elected officials and community people, do they tell you that the HIDTA and COPS grants should be reduced, the elimination of the Byrne grants? I mean, did they tell you that?

Mr. BURNS. I didn't hear that.

Mr. CUMMINGS. You didn't hear that.

Mr. BURNS. They did not tell us that they were in favor of reducing Byrne grants or HIDTA.

Mr. CUMMINGS. Did you ask them how they felt about it? These are the people who are the front line. These are the people that we have to face. These are the people who are suffering and trying to keep their communities together.

And I applaud you. I really do. I think it is wonderful that you went to the 25 areas. I think that is great. The question is, it is not the visit. It is what is happening during the visit and what kind of interaction there is.

Because, as the chairman has said, there are people who are crying out, and they are asking us to do something, and we are trying to get things done. We want to use the taxpayers' dollars effectively and efficiently.

You are telling me you are doing these wonderful tours, but I am wondering, No. 1, are you presenting to them—saying to them this is what we are proposing to do and this is why we think it is going to work. Then I want to know what they are saying back to you, and I can guess the reason why you are not hearing this is because a lot of them are very much opposed to this stuff.

Mr. BURNS. Let me tell you one thing that they are all saying——

Mr. CUMMINGS. Let me ask you one more question. Then I want to hear your answer. It is one thing for us to—for all of us to sit in nice offices and whatever and feel real good about what we are doing, read nice reports and put them on the shelf or whatever. It is another thing for that person who is out there dealing with this every day.

Some of the testimony that we heard, as a matter of fact in Congressman Souder's district, if I remember correctly, it was just so alarming and the struggles these people are having. I just want to know, how do we take your efforts out there, going out and doing your tour, and combine them and bring back something to your agency and the President so that we can be presented with something that is more reflective of what we are hearing, so that we can do for folks who are on the front line. I am not talking about somebody in an ivory tower. I am talking about somebody who is dealing with this every day. Help me with that.

Mr. BURNS. You are looking at the face of the administration of a person that deals with this every day. I don't sit in a nice office. I just spent the last few days in Chicago meeting with people from all over the country dealing with fentanyl. I've been to the chairman's district twice. We talked about drug-endangered children.

Mr. CUMMINGS. Then why are we—

Mr. BURNS. Let me just finish. I met with his prosecutor and the treatment officials, and we came up with a strategy for that particular part of the country. And I do it every day from California to Maine, Congressman—that is what the Office of National Drug Control Policy does—to bring forth a balanced strategy of prevention, treatment and law enforcement.

We may disagree on the numbers, we may disagree on the outcomes, but I can tell you in a lot of cities what they say is, thank God, there has been a 19.1 percent reduction in drug use among our young people. Thank God that methamphetamine use, as measured by the tool that we have used for a long time, shows a 30 percent plus reduction in methamphetamines among 8th, 10th and 12th graders.

Is there more work to do? Absolutely.

Mr. CUMMINGS. Did they say thank you for trying to cut our HIDTA program and to cut our COPS program? Did they say thank you for that, too?

Mr. BURNS. I think I answered that.

Mr. CUMMINGS. The answer is, no, is that right?

Mr. BURNS. That's correct.

Mr. SOUDER. My frustration—and I'm sorry Mr. Burns—I want to say Scott, but Mr. Burns, officially—I really appreciate that you came to my district. When you say we came up with a strategy, that is not the way local law enforcement would view what would happen in my district. They were already working on it. They don't view that ONDCP or that the meetings we held, which were good, came up with a strategy for meth. That was a slight overexaggeration of the meetings that we held.

And, second, when Mr. Cummings asked you what you were proposing to do on meth treatment, you didn't say anything. You had no answer. You filibustered for a while, but you had no answer.

I think a better representation of what ONDCP's position has been—not necessarily yours personally—was to say we don't like to do strategies on specific drugs which you had in the official testimony and because of that, it is very hard to answer.

In a couple of weeks, we will be holding a hearing in Montana. I venture to say that I will be able to ask every single witness a question like Mr. Cummings just said, what are you doing on treatment, and they will give a specific answer. There a businessman went in to Montana who wasn't from Montana. We're trying to figure out what impact it's had and all those type of questions.

But bottom line is they're going to give specifics. They're going to say, we put money in an ad campaign, we did this on treatment, we're doing this in the schools, we're having kids do pledges, this is our meth strategy. That is what we are looking for here, not some compilation of what Congress has passed and what State and locals are going to do, which, by the way, the administration proposed to cut, and that is part of our frustration.

Mr. BURNS. Can I respond to that briefly? Because you brought up the National Youth Media Campaign a couple of times.

Director Walters launched methamphetamine ads. As you know, they are targeted toward 23 major markets in this country. I think that the dialog that you and other members of this subcommittee had with Director Walters has been positive, and those ads are going forward today.

Mr. SOUDER. What was the total amount?

Mr. BURNS. The amount of the money? I do not know.

Mr. SOUDER. I think it is less than 5 percent.

I also know that Congressman Wolf designated that in an appropriations bill. It was not something that was necessarily voluntarily done, in that it was opposed when he designated it.

That is part of our frustration, that when Congress takes an action and then the administration does the minimalist strategy with it and then claims like it is a big meth initiative, we are not very impressed.

Mr. BURNS. Can I just say, as you know, Mr. Chairman, the National Youth Media Campaign is directed toward young people, 12 to 17 years old. Methamphetamine, the initiation age is 22. That's been part of the discussion that we have had with respect to how the media campaign is focused and directed. Our intent is to prevent young people from ever starting. We know if we can get a kid to 18 or 20 there is a 98 percent chance they will never be addicted to any drug. That's the policy and that's the strategy.

Mr. SOUDER. Ms. Watson.

Ms. WATSON. From my own experience in Sacramento, I looked for years for a program; and I think you just hit the real concern, is that possibly there was something for teenagers but this niece of mine died at age 22. I could not find a program that would take her.

Dr. Young said that you cannot put them back into the same community, to the same household where the problem existed. So you want to have somewhere, maybe a transition, after they got out of the hospital. And she was hospitalized almost every other month. After she got out of the hospital, she had to come back

home. The hospital would release her, put her in a taxi cab and put her on her mother's doorstep.

I would go from Washington, DC, to Sacramento. I represent Los Angeles. I live in Los Angeles, but I was involved as often as I could be.

What is missing out in the community are programs, halfway houses, places where a person who has just been emancipated, 18 years old but still young, can go for treatment and care and being taken out of the community. I want you to know in the Sacramento area meth is readily available. They bring it to you. You do not have to go to them. They bring it to you.

What I tried to do was to get her in a place. There were none. I had to get her in something called Teen Challenge. She was to go in on that Monday. She died Monday morning at 7:13 a.m. at age 22. I could not even get the hospitals to understand what we needed. They say, she's been here and there is nothing else we can do. Send her home. The last thing she said to me, 2 weeks before she died, Aunt Diane, I need help. I couldn't find the program. Teen Challenge, they take them up to 24, thank God. So I thought I could get her in there for 2 years at least. But there really aren't programs.

My question is, is there a way—and I have been reading through your report, and I appreciate the statistics that I find in here. But is there some way we can learn about programs in our local community that will take young people who have been emancipated, 18 and beyond?

We can go to the schools, and we can talk about it, but there really are not any real effective programs of prevention in schools. Because the health programs are the ones that are—usually have very low attendance, and we cut down on the staff and the faculty that would be providing the information. So what we need are community based kinds of walk-in programs if we are really going to do the job, because I think all the literature shows that meth use is done in the suburbs and the rural areas.

So I would like to see if you go to Sacramento, if you go to other parts of the country and you've talked to the medical community, law enforcement community, social services community, programs that they provide that we can put people in who are in great need but might not have the resources personally to deal with their problem. That would be very, very helpful. Then I think we could really feel the outreach.

I think it is out of control in the Sacramento area. I do not necessarily have that problem in my district. I have a crack cocaine problem in the central Los Angeles district, but methamphetamines, the use attacks the vital organs and will result in death. How can we stop it? What programs are available? Can you get information?

You can start with me with the Sacramento area. At least I can help somebody else in that area where I lived for 20 years, help families and so on. So if you could provide that information, what programs are available and what is the criteria for eligibility for those programs and what are the age spans, that would be very helpful to us. And I am sure in Baltimore it would be helpful and

Chicago and other areas where the problem is increasing—not decreasing, increasing.

Mr. BURNS. Let me just say this, and part of the challenge that we face nationally—if we have 19.1 million people using illegal drugs, we know about 7 million meet the definition of clinical addiction and about 2 million are currently in treatment. Part of the challenge we face nationally is getting the 5 million that are addicted to, No. 1, understand that they have a problem, because they don't think they do; and, No. 2, once that realization comes about, whether it is a crash of an automobile or an arrest at a nightclub when somebody is charged with a criminal offense, is then getting them into treatment.

I am sorry for your loss, and I mean that sincerely.

Ms. WATSON. Let me just interrupt you, because I have another committee I must go to, but we understand all of that. I am a former school psychologist in my other life. I understand that. Where can we go and get the kind of treatment—a person between these ages 18 and, say, 35, where can we go? What is available? Is there a directory? How do we access that information? How do we make the connection?

I could have called and said to her mother, take her here. I got to the social worker, and they looked all over the country, and there was nothing, there was nothing.

So your going to Sacramento, I don't know what it resulted in, but I can tell you what—and this is just recently. She died May 29th. You see, there was nothing except Teen Challenge, and they stretched it to let me get her in there.

Mr. BURNS. Well, I will provide for you the information with respect to treatment that is available in Sacramento area.

Ms. WATSON. That's what I need.

Mr. BURNS. I just wanted to finish my point. One of the things that we have funded and the national drug control policy is doing—and I give this to you by way of example following my last point of getting people into treatment—is funding what's called a screening or brief intervention program. We have professionals in emergency rooms and in division of family services offices trying to identify those people that are suffering from addiction and then get them into treatment. So there is a national effort to help those that are undergoing this condition.

Ms. WATSON. Can you supply—and I know I have been very personal with this, but I am sure my colleagues have the same needs, because in our offices walks every kind of issue imaginable. Is there a directory that is being developed that will put it in categories where people can go, numbers to call?

Because I went to social services in the county, and I could not find anything. So I went to a private organization, and that is where I found Teen Challenge. So if you could supply—and you might want to work on it nationally, wherever, you know, we have programs under the control of your program and Department. If you could supply it to all of us it would be a tremendous help. We will do the leg work, don't mind doing that, but we need to know on the other end of that there are those resources.

Mr. BURNS. Thank you.

Ms. WATSON. Thank you.

Mr. SOUDER. We are going to be voting shortly, but I wanted to ask Dr. Young one question. We may have some additional written questions from each of us as well.

But we had contacted FDA about what you were doing on pseudoephedrine and precursor chemicals some time ago and then received a letter back saying that was DEA that is in charge of that. But in your testimony you stated that FDA was co-chair with DEA. You said foreign pseudoephedrine co-chaired by FDA and DOJ; online diversion co-chaired by FDA and DEA. When we contacted you, you said, oh, we're not involved in this. This is DEA. What are you doing in those areas?

Dr. YOUNG. I will have to get back to you with more information for the record. So I will gather that together and get back to you for the record.

Mr. SOUDER. OK, I would appreciate that. Because we have this outstanding letter from a couple of months ago, and we just heard back before the hearing that we don't do that. But your testimony says you do, and we would like that reconciled.

Dr. YOUNG. I will get back to you, sir.

Mr. SOUDER. Thank you very much.

I want to thank each of you for what I know is hard work. I know the Department of Homeland Security will be continuing to track in your position as we see this become more and more of a border issue and an issue related to how it is getting into the United States. Your agency is going to be critical with that.

As we watch this move on line, I am sure a lot of the follow through, it is going to move and methamphetamine is going to start to behave like crack, marijuana, heroin and other types of drugs as it moves into these underground networks, and we will be working with you over time.

The treatment question is coming up in another hearing; and we will continue to work with Director Curry as well as you, Dr. Young. I look forward to your work.

Mr. Burns, continue to go out and talk with the State and locals. We hope the administration will hear a little bit more of what they are saying, particularly in the budget request.

With that, we will dismiss each of you. Thank you for coming.

Could the second panel come forward?

The second panel is the Honorable Eric Coleman, Oakland County commissioner in Michigan, a Detroit suburb, representing the National Association of Counties; Dr. Lewis Gallant, executive director, National Association of State Alcohol and Drug Abuse Directors; Ms. Sherry Green, the executive director of the National Alliance for Model State Drug Laws; Ms. Sue Thau, public policy consultant for the Community Anti-Drug Coalition of America; and Mr. Ron Brooks, president of the National Narcotics Officers' Associations' Coalition; director, Northern California Division HIDTA.

As an oversight committee, it is our standard practice to swear in all witnesses.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that each of the witnesses responded in the affirmative.

We thank you for coming; and, Mr. Coleman, we will start with you.

STATEMENTS OF ERIC COLEMAN, OAKLAND COUNTY COMMISSIONER, NATIONAL ASSOCIATION OF COUNTIES; LEWIS E. GALLANT, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS; SHERRY GREEN, EXECUTIVE DIRECTOR, NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS; SUE THAU, PUBLIC POLICY CONSULTANT, COMMUNITY ANTI-DRUG COALITIONS OF AMERICA; AND RON BROOKS, PRESIDENT, NATIONAL NARCOTICS OFFICERS' ASSOCIATIONS' COALITION, DIRECTOR, NORTHERN CALIFORNIA HIDTA

STATEMENT OF ERIC COLEMAN

Mr. COLEMAN. Thank you, Chairman Souder, for allowing me to appear this morning on behalf of the National Association of Counties on this critical issue of methamphetamine abuse and the recent release of the Synthetic Drug Control Strategy.

My name is Eric Coleman, and I am a county commissioner from Oakland County, MI. In addition, I am currently serving as first vice president of the National Association of Counties. The National Association of Counties [NACo], is the only organization that represents county government. With over 2,000 member counties we represent 85 percent of the Nation's population.

Abuse of a methamphetamine or meth is a growing issue for counties across the Nation. It is consuming a greater share of county resources because of its devastating and addictive nature.

In response to the administration's new Synthetic Drug Control Strategy, I would like to make two key points.

First, NACo commends the administration for now recognizing the dangerous threat posed by methamphetamines and developing a synthetic drug strategy to deal with this threat. However, NACo believes that the State and local government and law enforcement should have been consulted during the development of this strategy.

Second, NACo hopes that this strategy will translate into future budget requests for programs that are critical to fight methamphetamine abuse such as the Justice Assessment Grant program and the High Intensity Drug Trafficking Area program.

To illustrate the severity of the meth crises, NACo commissioned four surveys on the impact to county governments. Very briefly, our results have found that meth is the top drug threat facing county sheriff departments, that meth is leading to the alarming number of child out-of-home placements, that meth is the top drug seen at emergency rooms, and that the need for meth treatment is growing. These statistics confirm that meth is a national crisis that requires national leadership and a comprehensive strategy to fight this epidemic.

Consequently, we would like to commend the administration for recognizing the challenges of the meth crisis and putting forth a plan. However, a major weakness in this strategy is a lack of input from State and local governments and law enforcement. We hope that this disregard for State and local stakeholders can be remedied by the four inclusive meth summits that are planned for 2006.

If we had been consulted, NACo would have told the administration that their timeline to address the environmental dangers of meth production and use is unacceptable. The administration's plan to release voluntary clean-up standards in January 2011, is far too late. NACo has been a champion of the House-passed Meth Remediation Act and hopes that the Senate will pass the bill soon. These guidelines are desperately needed to provide direction to State and local governments and property owners on how to clean up a former meth lab.

Additionally, the strategy fails to mention the Substance Abuse Prevention and Treatment Block Grant, which amounts to about 40 percent of the total public funds spent on drug abuse prevention and treatment. NACo urges Congress to increase funding for this important program.

In contrast, NACo views administration's commitment to tightened control on the distribution of bulk pseudoephedrine on the international level as a positive. As a proponent to the Combat Meth Epidemic Act, which you sponsored, Mr. Chairman, we applaud their players who fully implement the legislation. Also, NACo supports the development and training of additional Drug Endangered Children teams. These teams play a vital role in responding to the needs of children affected by meth.

For this strategy to be an effective tool, the administration must commit additional resources to meth-related programs such as local enforcement, treatment and prevention. Programs such as JAG and HIDTA are critical to the local law enforcement's ability to tackle the meth crises. They have proven to be effective, and we urge Congress to reject the administration's budget proposal on these programs. Without a change in future budget requests for meth-related programs, this strategy will be nothing more than a government document sitting on a shelf.

In conclusion, I would like to thank you for the opportunity to appear before you today on behalf of NACo. We will be conducting further surveys on meth abuse and look forward to reporting our findings and working with you in resolving the meth crisis in this country. Thank you, and I will be happy to answer any questions you might have.

Mr. SOUDER. Thank you.

[The prepared statement of Mr. Coleman follows:]



**Statement of The Honorable Eric Coleman
Commissioner, Oakland County, Michigan**

**and First Vice President
of the National Association of Counties**

Before the

**United States House of Representatives
House Government Reform Committee**

**Hearing of the Subcommittee on
Criminal Justice, Drug Policy and Human Resources**

On behalf of

National Association of Counties

***Oversight Hearing on the
National Synthetic Drug Control Strategy***

June 16, 2006

NACo Statement Before House Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Thank you Chairman Souder, Ranking Member Cummings and Members of the Subcommittee. My name is Eric Coleman, I am a County Commissioner from Oakland County, Michigan, and I currently serve as the First Vice President of the National Association of Counties. I have served as a County Commissioner in Oakland County since 1996. Thank you for the opportunity to testify on the newly released Bush Administration *Synthetic Drug Control Strategy*.

About the National Association of Counties

Established in 1935, the National Association of Counties (NACo) is the only national organization representing county governments in Washington, DC. Over 2,000 of the 3,066 counties in the United States are members of NACo, representing over 85 percent of the population. NACo provides an extensive line of services including legislative, research, technical, and public affairs assistance, as well as enterprise services to its members. The association acts as a liaison with other levels of government, works to improve public understanding of counties, serves as a national advocate for counties and provides them with resources to help find innovative methods to meet the challenges they face. In addition, NACo is involved in a number of special projects that deal with such issues as the environment, sustainable communities and volunteerism.

NACo's membership drives the policymaking process in the association through 11 policy steering committees that focus on a variety of issues including agriculture, human services, health, justice and public safety and transportation. Complementing these committees are two bi-partisan caucuses—the Large Urban County Caucus and the Rural Action Caucus—to articulate the positions of the association. The Large Urban County Caucus represents the 100 largest populated counties across the nation, which is approximately 49 percent of the nation's population. Similarly, the Rural Action Caucus (RAC) represents rural county commissioners from any of the 2,187 non-metropolitan or rural counties. Since its inception in 1997, RAC has grown substantially and now includes approximately 1,000 rural county officials.

Methamphetamine

Methamphetamine or meth is a highly addictive homemade amphetamine that can be made from commonly found chemicals, such as pseudoephedrine, anhydrous ammonia, lye, phosphorous and antifreeze. Meth is an insidious drug that is cheap to produce that can be easily manufactured in virtually any setting; a car, house or deserted area. The drug can be smoked, snorted, injected or swallowed and releases an intense high for hours. Harmful long-term health risks from meth abuse include tooth and bone loss, damage to the user's brain, liver and kidneys, heart attack and stroke. Children who are exposed to the toxic chemicals during production of methamphetamine can also develop these conditions. In addition, the prolonged use of the drug, called "tweaking", can keep users up for days or weeks at a time. Consequently, the psychological side effects of meth use include paranoia, anger, panic, hallucinations, confusion, incessant talking and convulsions. Many of these lead to violent aggressive acts and suicide.

According to the 2004 National Survey on Drug Use and Health 11.7 million Americans had tried methamphetamine at least once – up nearly 40 percent over 2000 and 156 percent over 1996. In 2004, the survey notes that an estimated 1.4 million Americans regularly smoked, snorted or injected the drug.

NACo Statement Before House Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Historically, meth abuse was confined to the Western United States and to rural areas. However, the drug has quickly spread East and is having disastrous consequences in rural, urban and suburban communities nationwide.

Impacts of Methamphetamine Abuse on County Governments

County governments are on the front-line in dealing with the painful and costly consequences of methamphetamine abuse and production. The United States Drug Enforcement Administration estimates that 80 percent of methamphetamine is produced in “superlabs” in Mexico and California with the remaining 20 percent produced in “small toxic labs”. Since 2004, 35 states have passed laws that restrict access to pseudoephedrine. These laws have been credited with dramatically reducing small toxic meth labs. For example, the state of Iowa reported a decrease of nearly 80 percent since the passage of their law. During the height of small toxic labs and even now, these labs pose a significant risk to their community and represent the largest problem for local law enforcement.

Other costly effects of meth abuse on county governments include investigating and busting small toxic labs, incarcerating and adjudicating meth users and cleaning up former meth labs. County correction facilities are being overwhelmed by the increase in the number of meth related crimes and associated incarceration costs including mental health treatment, dental and other treatment costs. The need for and cost of county public defender services are also increasing at alarming rates because of the meth epidemic.

There are also many societal effects caused by meth abuse. In addition to broad criminal justice responsibilities, county governments are also the primary providers of public health and human services programs at the local level. In an alarming number of meth arrests, there are children living in the home. These children often times suffer from neglect and physical and sexual abuse. Additionally, as our survey demonstrates many meth users are presenting at county public hospitals without health insurance or are underinsured.

Meth labs pose a significant danger in the community because they contain highly flammable and explosive materials. Local first responders must be trained on how to identify and respond to meth labs in their communities. 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.

Meth abuse is a complex, difficult, growing problem that must be solved by cooperation among all levels of government and involvement by our citizenry. Since July 2005, NACo has been engaged in a national campaign to fight methamphetamine abuse. The primary objective of this initiative is to promote action by Congress and the administration to control and reduce the production, distribution and abuse of methamphetamine, including assistance to counties in responding comprehensively to the problem locally. Some of this work was completed with the passage of the Combat Methamphetamine Epidemic Act in March 2006, yet more work remains.

As part of this initiative, NACo President and Umatilla County, Oregon Commissioner Bill Hansell has appointed a cross-cutting work group that has county representatives from all perspectives of the issue. The charge of our Methamphetamine Action Group is to further assess the impacts of meth abuse on county governments, educate county officials and the public on the dangers of the

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drug and identify best practices and local approaches that address education, prevention, enforcement, cleanup and treatment of meth.

In addition, NACo will be conducting further surveys on other aspects of the methamphetamine crisis. We would welcome the opportunity to appear before this committee at a later date to discuss these findings.

This morning, I would like to make two key points:

- **First, NACo's commends the administration for now recognizing the dangerous threat posed by methamphetamine and for developing a synthetic drug strategy to deal with this threat. However, NACo believes that state and local governments and law enforcement should have been consulted during the development of this strategy.**
- **Second, NACo hopes that this strategy will translate into future budget requests for programs that are critical to fight methamphetamine abuse, such as the Justice Assistance Grant program and the High Intensity Drug Trafficking Area program.**

First, NACo's commends the administration for now recognizing the dangerous threat posed by methamphetamine and for developing a synthetic drug strategy to deal with this threat. However, NACo believes that state and local governments and law enforcement should have been consulted during the development of this strategy.

The new Synthetic Drug Control Strategy outlines a series of steps that the administration is going to take to reduce the illicit use of methamphetamine and prescription drugs. It sets to cut meth abuse by 15 percent over three years, a 15 percent reduction in prescription drug abuse and a 25 percent reduction in domestic methamphetamine labs over three years.

The development of a plan is an encouraging step to NACo because of the administration's acknowledgment that meth poses a danger across the nation. Since July 2005, NACo has been a leader in developing new research on the impact of methamphetamine on communities and county services. These surveys have demonstrated that there is a national meth crisis and that it requires national leadership to meet the challenge.

In the first survey, entitled, *The Criminal Effect of Meth on Communities*, is based on results from 500 county law enforcement agencies from 45 states. The counties that participated in the survey are representative of all counties nationally based on population and regional representation.

Of the 500 responding law enforcement agencies in the survey, 87 percent report increases in meth related arrests starting three years ago. The states reporting a 100 percent increase in meth related arrests during the last three years include Indiana, California, Minnesota, Florida and Ohio. Furthermore, Iowa and Mississippi reported a 95 percent increase and Illinois and North Dakota reported a 91 percent increase.

Additionally, 58 percent of county law enforcement agencies reported that meth is their largest drug problem. Meth outpaced cocaine at 19 percent, marijuana at 17 percent and heroin at 3 percent. In certain regions of the country, the percentages are even higher. In the Southwest, 76 percent of the

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counties said that meth is the biggest drug problem. In the Northwest, 75 percent said it was the top problem and by 67 percent of the counties in the Upper Midwest.

The survey showed that other crimes are increasing because of meth abuse. 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, 53 percent of respondents stated that simple assaults increased because of meth and 27 percent reported an increase in identity theft.

The increased presence of meth in many counties across the nation has increased the workload of 82 percent of the responding counties. These increased law enforcement activities from meth abuse are straining law enforcement budgets. Fifty-two percent of counties stated that they are paying more overtime, while 13 percent have changed work assignments to accommodate the increase need for policing.

Methamphetamine abuse is beginning to reach my home county, Oakland County, Michigan. The Oakland County Prosecuting Attorney's office reports that since October 2001, their office has processed approximately 30 cases involving either possession or possession with the intent to deliver methamphetamine.

The Impact of Meth on Children

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.

To assess this problem, NACo surveyed 303 counties from all 13 states where child welfare activities are performed at the county level to assess the danger to children and families from meth abuse.

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 percent of the responding counties in my home state of California reported an increase in out of home placements because of meth and 70 percent of Colorado counties reported an increase. The results in the Midwest are frighteningly similar. More than 69 percent of counties in Minnesota reported a growth in out of home placements because of meth during the last year, as did 54 percent of the responding counties in North Dakota. In addition, 59 percent of county officials reported meth has increased the difficulty of re-uniting families.

Treating Meth Addiction

In January 2006, NACo released two additional surveys on the impact of meth on the public treatment and hospital systems. The results of these surveys show that the methamphetamine epidemic has a broad impact on county provided services and continues to devastate America's communities.

In a survey, entitled, *The Challenges of Treating Meth Abuse*, behavioral health officials in 35 states were asked about drug treatment programs and how they have been affected by the methamphetamine epidemic. The results showed that the need for treatment programs for

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methamphetamine addiction is growing. Sixty nine percent of responding officials report an increase in the need for programs in their counties because of the growing use of methamphetamine.

Also, respondents noted that treatment for meth addiction is different from other drugs. Fifty four percent of the officials report that the success rate is different and 44 percent report that the length of time in the program is longer for meth addicts. Meth users seeking treatment require special protocols and longer treatment periods than users of other drugs. If treatment programs feature usual methods, the recidivism rate of meth users is higher than for other drugs.

The majority of respondents—63 percent—felt that they lack sufficient capacity to meet the needs for meth treatment and 57 percent say the reason is lack of funding.

Emergency Room Survey

In addition, NACo examined the effect of methamphetamine abuse on the public hospital system. In recent years, uninsured and underinsured individuals presenting at county hospitals have been a constant drain on county budgets. In the most recent fiscal downturn, one of the fastest growing elements of the budgets in many counties has been its public health facilities, its hospitals and its funding for payments for uninsured residents. By state law, many counties are the providers of last resort for people who need medical help, have no insurance and have no other place to go. This uncompensated care is growing in many communities and is becoming an increasingly large component of county budgets.

In a survey entitled, *The Effect of Meth Abuse on Hospital Emergency Rooms*, NACo received responses from 200 hospital emergency room officials in 39 states about the effect of meth on county public hospitals.

The results showed that there are more meth-related emergency rooms visits than any other drug. Forty-seven percent of 200 responding hospitals say that methamphetamine is the top illicit drug involved in presentations at their hospitals. The next highest involvement reported is marijuana at 16 percent.

The vast majority of responding hospitals have experienced increases in meth-related visits over the last 5 years. Seventy three percent of hospital officials report that emergency room presentations involving methamphetamine have increased over the last 5 years, and 68 percent reported continuing increases during the last three years.

Hospital presentations for meth are draining local budgets as these patients rarely have health insurance. Eighty three percent of the emergency room officials in this survey report that people presenting at their hospitals with a meth related emergency are often uninsured. As a result, hospitals have seen costs rise. Fifty six percent of hospitals report that costs have increased at their facilities because of the growing use of methamphetamine.

Future Surveys

In July 2006, NACo will be releasing a follow-up study to our previous study on the impact of meth on the criminal justice system. In particular, NACo will ask county law enforcement officials if the dramatic drop in small toxic meth labs has led to a decrease in meth arrests. Additionally, NACo

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will survey county Juvenile Detention Directors to examine the effect of methamphetamine on the juvenile detention population and system.

Synthetic Drug Control Strategy Specifics

The administration hails the success of the 35 states that have implemented pseudoephedrine precursor legislation and the potential impact of the Combat Methamphetamine Epidemic Act. However, to our knowledge these states or the local elected officials or law enforcement representatives that pushed for these laws were not consulted during the deliberations of this strategy. This lack of input by state and local officials and law enforcement does not create the necessary "buy-in" that will be needed to effectively fight methamphetamine abuse.

Furthermore, it is in direct conflict to the administration's statement in the strategy that, "State and local partners are crucial in carrying out the administration's strategy for the synthetic drug problem."

Moving forward, NACo hopes this disregard for state and local stakeholders can be remedied by the four inclusive meth summits that the Office of National Drug Control Policy (ONDCP) and the National Alliance for Model State Drug Laws is planning for 2006. Additionally, NACo looks to be an active participant in the eventual White House National Methamphetamine Summit that ONDCP is planning.

In light of our lack of participation, I would like to discuss NACo's views on the strategy's strengths and weaknesses. Many of the overarching themes of the strategy were included in NACo testimony to the subcommittee in July 2005 and subsequent testimony before the House Energy and Commerce committee in October 2005. In particular, NACo called for a comprehensive and intergovernmental approach to precursor control, law enforcement, treatment, cleanup of former clandestine labs, prevention, education and research.

Below is a description of the overall goals contained in the strategy.

Precursor Control

While many states have dramatically reduced methamphetamine labs through precursor restrictions, the success of state laws has been offset with the ever increasing amount of meth coming in from Mexico. The challenge now is to work on the international level with importing and exporting pseudoephedrine countries to tighten supplies of bulk precursor chemicals that are diverted to Mexican superlabs. The administration plans to achieve this goal by implementing a three-pronged approach. First, they plan to acquire better information about the international trade in pseudoephedrine and similar chemicals. The second objective is to implement the Combat Methamphetamine Epidemic Act. Lastly, the administration looks to continue law enforcement and border control activities, especially along the U.S.-Mexican border.

NACo views this three-part strategy as a good attempt to limit the diversion of bulk pseudoephedrine to methamphetamine producers. In particular, as a lead proponent of the Combat Methamphetamine Epidemic Act, NACo is encouraged that the administration plans to vigorously enforce the international provisions of the bill. The Act included provisions to close the spot market loophole and for the State Department to identify the top five importing and exporting countries and certify that these nations are cooperating with United States.

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Environmental Cleanup

One of the major issues facing communities and property owners is the issue of remediating former clandestine methamphetamine labs. As I noted earlier, the U.S. Drug Enforcement Administration estimates that only 20 percent of all methamphetamine is produced in these small toxic labs. However, these labs pose a significant risk to the community and individuals present at the manufacturing or use of the drug. The labs are highly toxic and the residual contamination from the production of methamphetamine can lead to health risks and threaten the health of children and individuals who may unsuspectingly live in a former meth lab.

Currently, there are no guidelines for local governments or private landowners to follow for remediating former clandestine meth labs. Additionally, several studies by Dr. John Martyny at the National Jewish Medical Center have shown that airborne and surface contamination from methamphetamine production or use can be far-reaching. Dr. Martyny found that residual contamination could last for long periods and cause serious health concerns for those individuals and children who are exposed knowingly or unknowingly.

The administration notes that much of the development of policy and law in the area of cleanup has occurred on the state level. This statement only belies the fact that the federal government has not been a leader in assessing the environmental damage posed by former meth labs. To remedy this lack of leadership, the administration commits to release a compilation of State guidelines in January 2008 and include any relevant research. In addition, the administration pledges to draft Federal health-based guidelines for remediation in January 2011.

NACo views this timeline as unacceptable. As a lead supporter of the bi-partisan Methamphetamine Remediation Act of 2005 (HR 798 / S 2019), we feel that federal voluntary guidelines are too important to wait 5 years. The legislation would require the Environmental Protection Agency to establish voluntary guidelines on the clean-up of former meth lab sites. The legislation has passed the House by voice vote and is awaiting consideration in the Senate Environment and Public Works Committee. Passage of this legislation and subsequent funding will expedite the dissemination of cleanup standards, which are critically needed to understand the true dangers of meth contamination.

Drug Endangered Children

Across the nation, alarming rates of children are found present at clandestine meth labs. In 2003, approximately 3,000 children were found during meth lab seizures. In the Western United States, the numbers are more frightening, as Assistant United States Attorney Laura Birkmeyer noted in testimony to this subcommittee. Birkmeyer stated, that in San Diego, "Drug Endangered Children 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 1 in 10 of these children tested positive for methamphetamine and of those the children ages 0-6 were twice as likely to test positive for methamphetamine as children aged 7-14."

To better coordinate and respond to the needs of these innocent victims, a Drug Endangered Children pilot program was started in 1997 in California. Drug Endangered Children are those children who suffer physical or psychological harm or neglect resulting from exposure to illegal drugs or to dangerous environments where drugs are being manufactured or chemicals used to make

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drugs are accessible. These harms may include injury from explosion, fire or exposure to toxic chemicals found at clandestine lab sites; physical abuse; sexual abuse; medical neglect and; lack of basic care including failure to provide meals, sanitary and safe living conditions or schooling.

A Drug Endangered Children (DEC) program is a multi-disciplinary team made up of law enforcement, medical professionals, prosecutors and child welfare workers. Team members are trained to view children found at narcotics crime scenes as crime victims. A typical scenario involves law enforcement breaking up a meth lab and contacting local child welfare officials if a child is present. The child welfare professional assesses the crime scene with law enforcement and determines if the child should be placed in protective custody. An at-risk child would then be given a medical exam, toxicology screen and developmental evaluation. The child would then be placed in a safe foster care environment. The prosecutor would then determine if child endangerment charges are appropriate. This concept bridges the gaps that often exist between these agencies. Furthermore, it represents a comprehensive approach to responding to the health risks of meth posed to children.

NACo is heartened by the administration's support for drug endangered children programs and for their commitment to continue to fund training programs through the National Alliance for Drug Endangered Children. Furthermore, NACo hopes that the administration's pledge will extend to requesting the full \$20 million for DEC programs that was authorized in the Combat Methamphetamine Epidemic Act for FY2008. This funding is critical to expand the reach of DEC programs in counties across the nation.

Prevention/Education

Educating youth on the dangers of methamphetamine abuse is critical to reducing first time meth users. Many former meth users indicate that they did not know the ingredients and dangerous consequences of the drug before their first use. NACo supports the National Youth Anti-Drug Media Campaign and the Partnership for a Drug Free America's efforts to reduce drug use through multi-media commercials. In late 2005, the Partnership released a new campaign designed specifically to reduce methamphetamine abuse and has plans to expand the campaign to an additional ten states. For this reason, NACo and a number of groups are supporting an additional \$25 million for the National Youth Anti-Drug Media Campaign for a total level of \$145 million in FY2007.

Additionally, NACo is disheartened by the increasing disparity between demand and supply reduction programs in the overall budget to fight drugs. Over the FY2001-FY2007 period, demand reduction programs have been increased by only 1 percent or \$49 million. In contrast, supply reduction programs increased by \$3.2 billion for a 66 percent increase. To effectively fight methamphetamine and other drugs, both supply and demand reduction must be emphasized.

Treatment

Despite a pervasive myth that treatment is ineffective for meth users, meth addiction can be treated similar to other forms of substance abuse. Treatment has been proven effective when it is available and the individual is willing to accept it. The Matrix Model, for example, consists of a 16-week intervention that includes intensive group and individual therapy to promote behavioral changes needed to remain off drugs.

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According to the National Association of County Behavioral Health and Developmental Disabilities Directors, a NACo affiliate, there are 22 states with county sponsored substance abuse treatment authorities. These states account for 75 percent of the nation's population.

It is disconcerting that the administration's strategy is silent on the Substance Abuse Prevention and Treatment Block Grant, which is the main source of funding for states' substance abuse programs and accounts for about 40 percent of the total public funds spent on drug abuse prevention and treatment. States receive this funding and disburse much of it to counties to fund drug treatment programs. Current year funding for the block grant is \$1.758 billion. The House Appropriations committee increased funding by \$75 million to \$1.834 billion. NACo supports this increase and would urge members of Congress to accept this funding level. This increase is critically important in light of NACo's recent survey that showed a lack of capacity at the local level to address meth treatment.

Drug Courts

NACo commends the administration for their continued support for drug court programs and their budget increase for FY2007. Drug courts represent an alternative for non-violent offenders to become drug-free through comprehensive supervision, drug testing, treatment services and intermediate sanctions.

Public Health

The administration's strategy is silent on the impact that methamphetamine is having in the public health sector. The National Institute of Drug Abuse (NIDA) notes that methamphetamine users, especially those that inject the drug and share needles, are at an increased risk to contract HIV and Hepatitis C. In addition, NIDA reports that methamphetamine can increase the libido in users, which may lead them to practice unsafe sex and lead to transmitting HIV and Hepatitis C. This data supports recent news accounts and research that this is particularly the case in urban areas with the gay population. To date, NACo has not yet examined the impacts of an increase in these and other sexually transmitted diseases on the county public health system but initial evidence shows that there is a correlation between methamphetamine use and infection.

Additionally, a consequence of methamphetamine abuse is "meth mouth", which is the rapid decay of tooth enamel. In rural America, meth mouth creates a unique problem because of the lack of dentists, endodontists and oral surgeons. According to the American Dental Association, of the 3,066 counties in the U.S., there are 250 counties without a dentist, nearly 2,200 without an oral surgeon and nearly 2,500 without an endodontist. These statistics suggest that multi-county or regional solutions must be developed to meet this gap in dental coverage across the U.S.

Second, NACo hopes that this strategy will translate into future budget requests for programs that are critical to fight methamphetamine abuse, such as the Justice Assistance Grant program and the High Intensity Drug Trafficking Area program.

The administration states, that the Synthetic Drug Control Strategy, "does not simply make recommendations for government action, but in fact commits the administration to a concrete course of action designed to achieve the aforementioned goals." NACo is hopeful that by committing to this course of action the administration will increase funding for meth-related programs in their FY2008 budget request, if not in FY2007.

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A critical element for state and local law enforcement that was not specifically mentioned is the Justice Assistance Grant (JAG) through the Department of Justice. JAG funding can be used for a variety of purposes including law enforcement, prosecution, prevention, education, drug treatment, planning, corrections and technology improvements. A growing number of counties have used JAG funds to combat the methamphetamine epidemic through multi-jurisdictional drug task forces. The program allows states and local governments to engage in a broad range of activities to prevent and control crime. It provides counties wide flexibility to prioritize at the local level and place justice funds where they are most needed.

Additionally, many counties receive Edward Byrne discretionary funding through congressional earmarks for similar programs. In FY2006, Byrne Memorial Justice Assistance Grants was funded at \$417 million while Byrne Discretionary Grants received \$192 million for a total of \$609 million. The FY2007 Bush Administration called for the elimination of the JAG program.

JAG funds can be spent on law enforcement programs; prosecution and court programs; prevention and education programs; corrections and community corrections programs; drug treatment programs; and planning, evaluation and technology improvements.

The President's budget request claims that the Byrne JAG program is not able to demonstrate "an impact on reducing crime." This is disputed by state and county studies. In 2004 alone, the National Criminal Justice Association found that JAG funds were responsible for:

- 54,050 weapons seized;
- 5,646 methamphetamine labs seized; and
- Massive quantities of narcotics removed from America's streets and \$250 million in seized cash and personal property (not including the value of narcotics seized)

JAG is only a small fraction of the massive resources state and local governments commit to criminal justice. In 2002, the latest year for which aggregate Census Bureau statistics are available, the following amounts were spent by state and local governments on justice programs:

- State Direct Justice Expenditure \$60,295,081,000
- Local Direct Justice Expenditures: \$87,251,684,000
- Total State and Local Justice Expenditures: \$147,445,745,000

JAG funding clearly does not supplant funding by state and local governments for justice and law enforcement programs. Rather, it provides minimal but essential funding that leverages state and local investment in justice programs.

NACo, along with a number of organizations, supports a level of \$1.1 billion for the Justice Assistance Grant program funding in FY2007 and urges members of the House of Representatives to support that level.

Another puzzling aspect of the strategy is that the administration highlights the benefits of shared intelligence, which is utilized in the High Intensity Drug Trafficking Area (HIDTA) program. Furthermore, the strategy states that, "intelligence-based initiatives that capture, assess, coordinate, and share information from Federal, State and local agencies are the most effective means of accomplishing this objective." This seems to be in direct conflict with the administration's proposals to cut funding for HIDTA's in FY2007 and transfer the program to the Department of

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Justice's Organized Crime Drug Enforcement Task Force. NACo supports the current year funding level for HIDTA because of the success the program has had with reducing the supply of drugs across the nation. In testimony to this subcommittee on May 23, Tom Carr, the Director of the Washington/Baltimore HIDTA, cited some of the successes of the HIDTA program. He stated that HIDTA, "yields a return on investment of \$63 for every program dollar invested, seizes \$10.5 billion in illicit drugs at wholesale value, nearly \$0.5 billion in illegal assets, dismantles and disrupts 3,538 drug trafficking organizations and money laundering operations and destroys more than 4,500 clandestine methamphetamine labs."

Moreover, in light of the major cut backs in the state and local portion of the Department of Justice budget (DOJ), NACo does not favor transferring this program to the Department of Justice. ONDCP's position within the Executive Office of the President enhances the HIDTA mission.

NACo hopes that this new strategy will lead the administration to consider increasing funding for state and local law enforcement. The JAG and HIDTA programs have demonstrated results, yet both have received cuts in the administration budget, especially JAG, which was zeroed out.

To make this strategy effective, the administration must commit resources to fighting methamphetamine and prescription drug abuse. Increased funding for local law enforcement, treatment, prevention and education are critical. Without this funding, the strategy is only a document and not a plan for action.

Conclusion

On behalf of NACo, I would like to thank Chairman Souder and Ranking Member Cummings for holding this hearing today. As our surveys have demonstrated, methamphetamine abuse has reached epidemic proportions that must be addressed in a comprehensive manner by all forms of government. NACo looks forward to working with Congress and the Administration to craft and implement such legislation.

Lastly, NACo will be conducting several additional surveys on other aspects of the methamphetamine epidemic. As I mentioned earlier, the next round of surveys will include a release of updated criminal justice data and an examination of the impact of meth on the juvenile detention system. We would welcome the opportunity to come before this committee and present our findings at the appropriate time. Again, we thank the Chairman, the Ranking Member and members of the subcommittee for the opportunity to submit testimony on the methamphetamine crisis facing the nation.

Mr. SOUDER. Dr. Gallant, it is good to have you back.

STATEMENT OF LEWIS E. GALLANT

Mr. GALLANT. Thank you, Mr. Chairman.

Chairman Souder, Ranking Member Cummings, and Congresswoman Watson, I am Dr. Lewis Gallant, executive director of the National Association of State Alcohol and Drug Abuse Directors [NASADAD]. Thank you for your leadership and seeking input regarding the Synthetic Drug Control Strategy.

NASADAD members have the front-line responsibility of managing our Nation's publicly funded substance abuse system. NASADAD's mission is to promote an effective and efficient substance abuse system.

The Association's No. 1 message is this: People suffering from methamphetamine addiction, just like those suffering from addiction to other substances of abuse, can recover and do recover. This message of hope, grounded in science, proven through data and illustrated every day by countless Americans living in recovery serves as a linchpin of our work.

Turning to the Synthetic Drug Control Strategy, the Association agrees with the administration's assessment that a comprehensive approach is needed in order to achieve success and that the manifestation of the synthetic drug problem in one State may be very different from that in another State. I offer to the committee five core recommendations: First, coordinate and collaborate with single State Authorities for Substance Abuse [SSAs]. The job of each SSA is to plan, implement and evaluate a comprehensive system of care.

As a former State substance abuse director of Virginia, I know firsthand the benefits of promoting interagency coordination. From public safety to child care, transportation to employment, State addiction agencies need to be at the table when initiatives are developed and implemented.

Second, expand access to treatment and treatment infrastructure. The No. 1 priority for NASADAD is the Substance Abuse Prevention and Treatment Block Grant, the foundation of our treatment system and a program not mentioned in the Synthetic Drug Control Strategy. Sample data from three States demonstrate the following for block grant support service for methamphetamine addiction: In Colorado, 80 percent of the methamphetamine users were abstinent at discharge in fiscal year 2003. A 2003 study found that 71.2 percent of methamphetamine users were abstinent 6 months after treatment, and in Tennessee over 65 percent of methamphetamine users were abstinent 6 months after treatment.

NASADAD is aware of this committee's interest in improved data reporting. The Association is partnering with SAMHSA to make excellent progress in implementing the National Outcome Measures [NOMs], initiative. NOMs is designed to improve our system by emphasizing performance and accountability through data reporting on core sets of measures from all States, across all SAMHSA grants, including the SAPT Block Grant.

Moving on to No. 3, enhanced prevention services and infrastructure. Once again, the SAPT Block Grant is vital, dedicating 20 percent of its funding, or \$351 million, to support important prevention services that help keep our kids drug free.

The Association strongly supports SAMHSA's Strategic Prevention Framework State Incentive Grants. However, we remain concerned with the administration's proposed cut of \$11 million to the framework and extremely concerned with the proposal to eliminate altogether the Safe and Drug Free Schools State Grant Program.

No. 4, solid support for research is vital, especially at the National Institute on Drug Abuse, so that we may build on the Institute's impressive portfolio.

No. 5, enhance tools to share knowledge and best practices. The Addiction Technology Transfer Centers [ATTCs], and the Centers for the Application of Prevention Technologies [CAPTs], are regional centers funded by SAMHSA that help train our work force through distance learning and other mechanisms and share best practices to help ensure that we are implementing effective programs backed by the latest science.

I have run out of time, but let me say that States across the country are moving forward to implement cutting-edge initiatives. We look forward to working with all stakeholders to continue the momentum and improve our collective work on methamphetamine and prescription drug abuse. I welcome any questions you might have.

Mr. SOUDER. Thank you.

[The prepared statement of Mr. Gallant follows:]



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**Oversight Hearing:
Evaluating the Synthetic Drug Control Strategy**

**Friday, June 16, 2006
2247 Rayburn House Office Building**

**House Government Reform Subcommittee on Criminal Justice,
Drug Policy and Human Resources**

**The Honorable Mark E. Souder, Chairman
The Honorable Elijah Cummings, Ranking Member**

Testimony Submitted by:

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Chairman Souder, Ranking Member Cummings, Members of the Subcommittee, I am Lewis E. Gallant, Ph.D., Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Two component organizations of NASADAD include the National Prevention Network (NPN) and the National Treatment Network (NTN). Thank you for holding this hearing to discuss the Administration's Synthetic Drug Control Strategy: A Focus on Methamphetamine and Prescription Drug Abuse. We sincerely appreciate the opportunity to provide testimony. We offer our support and commitment as we work together to address the problems associated with methamphetamine and prescription drug abuse.

Number One Message: People Can and Do Recover from Methamphetamine

Addiction: If there is but one message to convey to the public regarding methamphetamine in particular, it is this: people can and do recover from methamphetamine addiction. This message of hope, grounded in science, proven through data, and illustrated every day by the countless Americans living in recovery, serves as a lynchpin to any set of recommendations related to the Synthetic Drug Strategy. Indeed, methamphetamine may present unique challenges for our State systems. However, research has shown that clinically appropriate services (screening, assessment, referral, individualized treatment plans within the appropriate level of care and for the indicated duration of treatment, along with aftercare and other supports) provided by qualified staff help people with methamphetamine addiction begin the journey into recovery.

Core NASADAD Recommendations: NASADAD agrees with the Administration's view that a comprehensive approach is needed to successfully address the problems associated with methamphetamine and prescription drug abuse. In particular, the three-prong strategy relayed by the Administration (stopping drug use before it starts, healing Americans with substance use disorders and disrupting the market) provides a valuable framework to discuss these issues. For this hearing, NASADAD is focusing on prevention, education, treatment, recovery and research and offers the following core recommendations:

- **Coordination with Single State Authorities (SSAs) for Substance Abuse**
- **Expand Access to Treatment**
- **Strengthen Prevention Services and Infrastructure**
- **Enhance Tools to Share Knowledge and Best Practices**
- **Continue to Support Research**

These recommendations will be reviewed in the context of the Administration's Synthetic Drug Strategy as we work together to improve our response to the problem of addiction.

NASADAD Members and Mission: NASADAD represents State Substance Abuse Agency Directors – also known as Single State Authorities (SSAs) for Substance Abuse. SSAs have the front line responsibility for managing our nation's publicly funded prevention and treatment service system – including the Substance Abuse Prevention and Treatment (SAPT) Block Grant. NASADAD's mission is to promote effective and efficient State substance abuse service systems.

NASADAD Policy Priorities: NASADAD's key policy priorities for 2006 are to (1) Strengthen State substance abuse systems and the office of the Single State Authority (SSA), (2) Expand access to prevention and treatment services, (3) Implement an outcome and performance measurement system, (4) Ensure clinically appropriate care, and (5) Promote effective policies related to co-occurring populations.

Methamphetamine Use and Prevalence: According to the National Survey on Drug Use and Health (NSDUH), approximately 12 million Americans ages 12 or over tried methamphetamine in 2004. The NSDUH also found that the number of past month methamphetamine users who met the criteria for drug dependence or abuse in the past year doubled: from 27.5 percent in 2002 to 59.3 percent in 2004. The Drug Abuse Warning Network (DAWN), which monitors drug use reports in emergency departments in certain parts of the country, detected a steep rise in methamphetamine related visits over the past 10 years – with approximately 15,000 in 1995 compared to 39,000 in 2002.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently reported (March 2006) that methamphetamine/amphetamine admissions increased in the U.S. for those 12 and older from 13 to 56 admissions per 100,000 from 1993 to 2003. States with admission rates higher than the national average include Arkansas, Oklahoma, Iowa, Kansas, Minnesota, Missouri, Nebraska, South Dakota, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming. SAMHSA also noted that the following States recently experienced large increases in methamphetamine/amphetamine admissions while still remaining below the national average: Alabama, Georgia, Louisiana, Texas, Illinois, Indiana, and North Dakota.

Although most Americans understand that methamphetamine is a national problem, many are unaware of its impact on women. From 1995 to 2003, according to SAMHSA, the number of women admitted for methamphetamine treatment has almost doubled - from 6.1 percent in 1995 to 11 percent in 2003. The number of pregnant women admitted for methamphetamine treatment during this same time frame increased at a similar rate - from approximately 10 percent in 1995 to approximately 20 percent in 2003. Young women are also using methamphetamine at higher rates compared to men. In 2002, 57 percent of all methamphetamine treatment admissions for those ages 15 to 17 were female and 70 percent of methamphetamine treatment admissions for those ages 12 to 14 were female.

We also know that children can be impacted by methamphetamine. According to the National Center on Substance Abuse and Child Welfare (NCSACW), children are most often exposed to methamphetamine through the use of this addictive drug by his or her parents. At times, these situations can ultimately impact our child welfare and criminal justice systems and threaten the permanency of families across the country. Overall, more than two-thirds of parents involved in the child welfare system need addiction treatment - and methamphetamine can often be a parent's drug of choice. In Arizona, for example, methamphetamine was the most common substance reported at admission among parents referred to treatment through a Child Protective Services program called Families FIRST

(40 percent in 2003-2004). Another example is Oregon, where 69.7 percent of children's parents involved in the foster care system received treatment for methamphetamine use.

Non-Medical Use of Prescription Drugs: The NSDUH estimates that 6 million Americans or 2.5 percent of the population used prescription drugs non-medically in 2004. In particular, there were approximately 4.4 million current users of narcotic pain relievers, 1.6 million users of tranquilizers, 1.2 million used stimulants and 300,000 used sedatives. In 2004, approximately 2.4 million people were new users of pain relievers non-medically. A distinct concern is the increase of non-medical use of prescription medications among young adults. The NSDUH notes that in 2004, 6 percent of young adults used medications non-medically in the past month, and 29 percent tried these drugs at least once.

A 2006 study by researchers at the University of Michigan examined the non-medical use of prescription drug abuse and stimulants among secondary and college students. The study on secondary students found that students using prescription drugs non-medically were 8 times more likely to use other illegal drugs; approximately 25 percent of students prescribed stimulants for ADHD were approached to divert their medication; 53 percent took stimulants to get high; 40 percent took them to increase alertness; 36 percent took them to help them concentrate; and 28 percent took them to lose weight. For college students, the study found that 58 percent diverted pain medication from their peers; 12 percent diverted pain medication from their family; 66 percent of women and 60 percent of men took prescription drugs non-medically in order to relieve pain.

Overview of Administration's Synthetic Drug Control Strategy: The Synthetic Drug Control Strategy is designed to outline the Administration's approach to the problems related to methamphetamine and prescription drug abuse. Overall, the Administration calls for "a balanced approach incorporating prevention, treatment, and market disruption initiatives..." and reviews both international and domestic initiatives.

For methamphetamine and prescription drug abuse treatment, the Strategy focuses on increased support for drug courts and other programs that expand access to addiction treatment. For prevention, the Strategy focuses on strong support for the Youth Anti-Drug Media Campaign and the Strategic Prevention Framework (SPF). For both treatment and prevention, the Strategy calls on additional research to ensure that practice and policy is informed by science.

The Administration also set ambitious goals. In particular, the Strategy sets the following goals over the next three years: (1) reducing past-month use of methamphetamine by 15 percent, (2) reducing past-month use of prescription drug abuse by 15 percent, and (3) reducing domestic methamphetamine laboratories by 25 percent.

Other parts of the Strategy of immediate interest to NASADAD include the promotion of State and city drug control strategies, assisting children impacted by methamphetamine, and prescription drug monitoring programs.

General NASADAD Observations: NASADAD supports the Administration's call for a balanced approach to addressing the problems of synthetic drugs. We strongly agree that an effective strategy includes prevention, treatment and market disruption initiatives.

In addition, we agree with the Synthetic Drug Control Strategy's view that "...the manifestation of the synthetic drug problem in one State may be different from that in another State." As a result, the Association believes successful federal initiatives acknowledge that each State substance abuse system is unique and faces distinctive challenges.

As we look at methamphetamine, for example, Ohio experienced a total of 399 admissions in 2004. In contrast, California saw 72,959 admissions in 2004-2005. While both States are taking action to address methamphetamine, the specific needs of each State – and the service delivery systems themselves – differ greatly. In turn, these challenges require unique responses that should be tailored to fit the manner in which the State is organized to better address State, county and local circumstances. To help illustrate the variation in each State, we have attached, at the end of this testimony, State Snapshots on Methamphetamine for the jurisdictions represented on this Committee (**Attachment 1**). These Snapshots also help illustrate the wide variety of actions that Governors are moving forward to address methamphetamine.

The Administration recommends that each State develop a drug strategy to help address the problem of drug abuse. Indeed, NASADAD values the utilization of appropriate planning and evaluation tools to proactively address addiction issues. To begin, the SAPT Block Grant application requires a needs assessment and coordinated State plan as a condition of receiving funds. In addition, States use a variety of mechanisms to create comprehensive approaches to addiction prevention, treatment, education and research.

For example, the Governor's Commission for a Drug Free Indiana serves as an interagency planning body to ensure that relevant public and private partners develop a comprehensive approach to addiction. Each year, sub-State planning regions submit plans to the Commission for approval that are then fused into a larger State strategy. A key aspect of this Commission is the inclusion of the SSA as a critical partner. In Maryland, the Governor established the Maryland Drug and Alcohol Abuse Council that includes interagency representatives – including the SSA. As noted by the Council, "a major responsibility of the Council is to prepare and annually update a two year strategic plan with priorities for delivery and funding of services in the State." The Governor's Council in turn works with each of the local county councils on planning and service delivery. These are just two examples of how States work to strategically plan comprehensive and coordinated addiction systems.

Below, NASADAD would like to offer more specific recommendations on improving our collective response to methamphetamine and prescription drug abuse. Again, these recommendations will focus on prevention, treatment, research and recovery. We believe these recommendations represent an important part of any comprehensive plan to address these important issues.

Specific Recommendations

Coordination with Single State Authorities (SSAs): As noted above, State Substance Abuse Directors, also known as Single State Authorities (SSAs), manage the publicly funded treatment and prevention system. Their job is to plan, implement and evaluate a Statewide comprehensive system of clinically appropriate care. Everyday, SSAs work with a number of public and private stakeholders given the fact that addiction impacts everything from education, criminal justice, housing, employment and a number of other areas.

This collaboration is illustrated by the National Institute on Drug Abuse (NIDA) in its “Principles of Effective Drug Treatment,” which demonstrates how addiction treatment is linked with a number of other services – including child care, housing, transportation, vocational services and more (**Attachment 2**). With this in mind, Federal initiatives regarding synthetic drugs – including methamphetamine and prescription drugs – would benefit from close coordination with SSAs given their unique role in planning, implementing and evaluating State addiction systems.

An illustration of the collaborative work done by SSAs is their interaction with the child welfare system. SSAs across the country work and collaborate with law enforcement, social services, child welfare agencies and others to ensure child safety, protection and permanency, and effective methamphetamine addiction treatment for family members.

A specific initiative designed to improve collaboration across State substance abuse, child welfare and other agencies in order to improve outcomes is the work of the National Center on Substance Abuse and Child Welfare (NCSACW). NASADAD is a member of this SAMHSA-Administration for Children and Families (ACF)-funded initiative and believes this project is assisting State agencies to improve practice and policy. For example, the NCSACW helped develop a protocol in Colorado for counties, providers and judicial districts to improve services by coordinating the substance abuse, child welfare and dependency court systems. Similarly, work was done in Virginia to help develop a Memorandum of Understanding between the Department of Social Services, State substance abuse agency, and the Office of the Supreme Court of Virginia to help better serve children and families in need of addiction services.

As we look at prescription drug abuse, more States are moving forward to establish and implement Prescription Drug Monitoring Programs (PMPs) to help identify drug diversion and “doctor shopping.” NASADAD recognizes the value of PMPs in addressing prescription drug abuse. NASADAD also strongly supports an appropriate link between the SSA and a State’s PMP. We agree with Senate Report 109-117, which accompanied the passage of the National All Schedules Prescription Electronic Reporting (NASPER) Act, which noted that the “...committee believes an important component of any strategy relating to prescription drug monitoring programs is a strong link with each State’s Single State Authority (SSA) for Substance Abuse...This important link with the SSA will help provide access to clinically appropriate treatment services for persons

addicted to prescription drugs and enhance opportunities to build a strong and comprehensive prevention portfolio related to the misuse of prescription drugs.”

NASADAD also wishes to recognize the excellent work of the National Alliance for Model State Drug Laws (NAMSDL) on issues pertaining to both prescription drugs and methamphetamine. Meetings coordinated by the Alliance review State laws and initiatives regarding PMPs, discuss policies regarding methamphetamine precursor chemicals, analyze effective data sharing policies and review other important issues facing States across the country. The Alliance often includes NASADAD as a speaker at these meetings in order to ensure that the views of the SSAs are included and considered. NASADAD members and staff consistently attend these meetings and find them extremely valuable and informative.

Synthetic Drug Control Strategy: As noted by the Administration, “Most government-supported treatment, although often funded by Federal grants, is implemented by State or local officials.” Indeed, 42 percent of substance abuse expenditures came from State, county and local sources in 1991. This percentage changed in 2001, where State, county and local expenditures now represent about 50 percent of substance abuse expenditures. As a result, the Strategy notes that “the Administration will continue to partner with State, county, tribal, and city governments over the next three years to attack the illicit use of methamphetamine.” We support such a partnership.

NASADAD also appreciates the Administration’s support of regional and other meetings on methamphetamine and prescription drugs. NASADAD applauds SAMHSA’s Division of State and Community Assistance (DSCA) for their hard work to sponsor, plan and implement two meetings (in California and Florida) to specifically discuss methamphetamine treatment. SSAs and NASADAD look forward to additional regional meetings on methamphetamine to be sponsored by the Department of Justice (DOJ), Office of National Drug Control Policy (ONDCP), in concert with the NAMSDL. The first regional meeting is scheduled to take place in mid-July in Alabama.

Expand Access to Treatment: As stated earlier, research and data tell us that people can and do recover from methamphetamine addiction. As a result, NASADAD strongly believes that one pillar of any successful strategy related to methamphetamine and prescription drug abuse is expanding access to clinically appropriate treatment.

For methamphetamine treatment, as for addiction treatment in general, the number one federal program priority for NASADAD is the *Substance Abuse Prevention and Treatment (SAPT) Block Grant*. The SAPT Block Grant is an efficient and effective program that serves as the foundation of our publicly funded prevention and treatment system. This flexible funding stream is designed to help States address their own unique needs related to addiction at the State, county and local level – whether the primary problem is methamphetamine or prescription drugs, heroin or cocaine, or any of the many other substances of abuse that threaten our families and communities. Overall, the SAPT Block Grant provided support in 2001 to over 10,500 community-based organizations across the country.

NASADAD understands that the Committee has expressed support for improved data reporting in order to assess the effectiveness of services funded by the SAPT Block Grant. NASADAD strongly supports the use of performance and outcome data to help improve services and improve lives. In fact, SSAs and SAMHSA agreed to implement the National Outcome Measures (NOMs) initiative in order to improve service efficiency and effectiveness through the use of data indicators of accountability and performance. Specifically, States will report a core set of measures for all SAMHSA grants – including the SAPT Block Grant – and use Continuous Quality Improvement (CQI) and the driving force underlying NOMs implementation. A few examples of specific measures include abstinence from drug/alcohol use; employment/education; crime and criminal justice involvement; and access/capacity.

We are also pleased to report that current outcome data from State substance abuse directors demonstrate that SAPT Block Grant-funded services help people remain alcohol and drug free; obtain or regain employment; stay out of the criminal justice system; find stable housing; and begin the journey into recovery. SSAs also use data to demonstrate how SAPT Block Grant supported programs help people recover from methamphetamine addiction. A few State-specific examples are included below:

- *Colorado's Alcohol and Drug Abuse Division (ADAD)* reported that 80 percent of methamphetamine users were abstinent at discharge from treatment in FY 2003.
- *Iowa's Division of Behavioral Health and Professional Licensure* reported, in a 2003 study, that 71.2 percent of methamphetamine users were abstinent six months after treatment.
- *Minnesota's Division of Chemical Health*, in follow up data collected from 1993 through 1999, reported that 73 percent of a sample of the persons addicted to methamphetamine reported abstinence from any drug use 6 months after discharge.
- *Tennessee's Bureau of Alcohol and Drug Abuse Services*, in a 2002-2003 study, found that over 65 percent of methamphetamine users were abstinent six months after treatment.
- *Texas' Department of State Health Services* reported that outcomes data for publicly funded services from 2001 to 2004 found that approximately 88 percent of methamphetamine clients were abstinent 60 days from discharge.
- *Utah's Division of Substance Abuse and Mental Health* reported that 60.8 percent of methamphetamine users were abstinent at discharge in SFY 2004.

Additional data demonstrating the effectiveness and efficiency of the SAPT Block Grant are attached (**Attachment 3**).

NASADAD applauds the House Appropriations Committee for approving a \$75 million increase for the SAPT Block Grant in FY 2007. This increase will help offset the \$20 million cut absorbed by the program over the past two years. However, we must continue to highlight the overall addiction treatment gap facing our country. Approximately 23.5 million Americans were in need of services for an alcohol or drug problem in 2004. During the same year, approximately 3.8 million received treatment for alcohol or illicit drug use. As a result, approximately 19.7 million people needed but did not receive addiction treatment services in 2004.

NASADAD remains extremely concerned with the proposal by the House Appropriations Committee to cut the budget for the *Center for Substance Abuse Treatment (CSAT)*, led by Dr. H. Westley Clark, by \$72 million. CSAT funds the *Targeted Capacity Expansion (TCE)* program – another federal tool that helps States increase access to methamphetamine and other addiction treatment. For FY 2007, the House Appropriations Committee did approve \$25 million specifically for methamphetamine treatment. NASADAD applauds the committee for directing these grants to the States and affording States the flexibility to choose how best to purchase services instead of requiring successful applicants to use any one, predetermined purchasing mechanism.

The Department of Justice (DOJ) also provides critical resources that help support methamphetamine treatment. NASADAD supports the Administration's proposal to provide drug courts with \$69.2 million in FY 2007. The Association encourages additional work at the federal and State level to encourage more collaboration between drug courts and SSAs. In addition, NASADAD supports \$20 million in FY 2007 for a new methamphetamine treatment program appearing in Section 756 of the Patriot Act. In particular, the provision authorizes a grant to State substance abuse, child welfare and criminal justice agencies in order to expand methamphetamine treatment for pregnant and parenting women offenders.

NASADAD remains concerned, however, with proposals to cut other vital funding streams within DOJ. These proposals include:

- Elimination of the *Residential Substance Abuse Treatment (RSAT)* program that was funded at \$10 million in FY 2006 and \$24.7 million in FY 2005. NASADAD recommends \$40 million for this program in FY 2007.
- Elimination of the *Byrne/Justice Assistance Grant (JAG)* program that was funded at \$416 million in FY 2006 and \$634 million in FY 2005. NASADAD recommends \$634 million for this program in FY 2007.

These cuts place added pressure on a system already facing other cuts within DOJ's programming focused on substance abuse. For example, the Administration is proposing to eliminate the Enforcing Underage Drinking Laws (EUDL) program that was funded at \$25 million in FY 2006. In addition, the Administration is proposing to eliminate funding for the Mentally Ill Offender Act program that received \$5 million in FY 2006. NASADAD recommends level funding in FY 2007 for both programs.

Synthetic Drug Control Strategy: The Administration promoted the President's proposal to provide drug courts with \$69.2 million in FY 2007. The Strategy also highlights support for other programs designed to expand drug treatment services.

Strengthen Prevention Services and Infrastructure: NASADAD believes that a strong commitment to prevention services is vital in the fight against prescription drug and methamphetamine abuse. As noted in the Synthetic Drug Control Strategy, youth drug use has declined by 19 percent since 2001. NASADAD is pleased with this progress but recognizes the many challenges that remain.

The SAPT Block Grant, NASADAD's number one program priority, allocates 20 percent of funds to support prevention services. This prevention set-aside represents a critical investment that helps States implement prevention programming. Similar to treatment, States will be reporting to the federal government a core set of prevention measures through the NOMs initiative across all SAMHSA grants – including the SAPT Block Grant. A few examples of prevention measures include age at first use; perceived risk of use; and drug related crime.

The prevention set-aside received \$351.7 million in FY 2006, representing a cut of approximately \$3.4 million compared to the FY 2005 level of \$355.1 million. Again, NASADAD appreciates the House Appropriations Committee's vote to recommend an increase of \$75 million for the SAPT Block Grant which will help restore previous cuts to prevention services.

NASADAD also believes that an effective substance abuse prevention strategy requires strong investment in the *Center for Substance Abuse Prevention (CSAP)*, led by Acting Director Dennis Romero. One top program priority within CSAP is the Strategic Prevention Framework State Incentive Grants (SPF SIG) program. The State Prevention Framework incorporates a five step community model: (1) organize the community to profile needs, including community readiness, (2) mobilize the community and build capacity to address needs and plan for sustainability, (3) develop prevention action (evidence-based activities, programs, strategies, and policies); (4) implement the prevention plan; and (5) conduct an ongoing evaluation for quality improvement and outcomes.

NASADAD is very concerned with the proposal by the Administration to cut CSAP by \$12.3 million. A particular concern is the proposal to cut \$11.2 million from the SPF SIG program. NASADAD recommends \$205 million for CSAP in FY 2007 which would allow the agency to continue its goal of providing each State in the country with an SPF SIG. NASADAD recognizes the House Appropriations Committee for voting to provide CSAP with \$195.8 million for an increase of \$2.9 million over FY 2006.

More must be done to educate the public regarding the fact that people can and do recover from methamphetamine addiction. Forums such as this hearing will be critical to making progress in addressing the false perceptions of methamphetamine and addiction

treatment. In addition, support for prevention programs in our schools is a vital part of this education and outreach.

One important federal program that helps our efforts to prevent drug use in our schools is the *Department of Education's (Dept. Ed) Safe and Drug Free Schools and Communities (SDFSC) – State Grants Program*. For FY 2007, the Administration proposed to completely eliminate the SDFSC State Grants program – representing a cut of \$346.5 million. NASADAD recommends \$400 million for this program in order to ensure that an estimated 37 million youth receive vital prevention services to remain drug free. Governors receive 20 percent of the SDFSC State Grants allocation – assigning a designee to administer these funds. In certain States, SSAs serve as the lead for the Governor's share of SDFSC funding. Examples of SDFSC at work include:

- *California's Department of Alcohol and Drug Programs* targets special populations such as youth in juvenile detention centers, homeless children and pregnant/parenting teenagers.
- *Maine's Office of Substance Abuse* manages the entire SDFSC portfolio – funding every State school system as well as 9 community based programs – including the Prime for Life program in Augusta that serves youth who have violated school alcohol/drug policies and the Passages program in Camden that helps pregnant or parenting school drop-outs acquire their diploma.
- *Connecticut's* program supports the Neighborhood Youth Center Program designed to increase the range and extent of positive experiences for at risk youth in Bridgeport, Hartford, New Britain, New Haven, Stamford and Waterbury.
- *Nevada's Bureau of Alcohol and Drug Abuse* funded 5 programs in 17 counties that targeted youth in juvenile justice systems among other settings.

Synthetic Drug Control Strategy: The Administration joins NASADAD in highlighting the benefits of the SPF SIGs as “an ambitious effort to decrease substance use” in States across the country. The two other initiatives included in the Synthetic Drug Control Strategy include (1) the National Youth Anti-Drug Media Campaign and (2) the prevention portfolio within NIDA.

NASADAD supports the use of ad campaigns as part of a balanced approach to drug prevention efforts. In the process, NASADAD supports work to tailor ads to match the circumstances and needs of the local communities.

Enhance Tools to Share Knowledge and Best Practices: SSAs believe that information sharing regarding best practices, cutting-edge research, practitioner training, curriculum development and other issues is vital. Two SAMHSA-funded initiatives that fulfill these roles are the *Addiction Technology Transfer Centers (ATTCs)* and the *Centers for the Application of Prevention Technologies (CAPTs)*.

ATTCs began in 1993 and have grown into a national network with 14 regional centers and a national office serving all 50 states. The mission of the ATTC network is to bridge the gap between alcohol and drug treatment scientists and substance abuse treatment practitioners. Simply put, ATTCs help translate the latest science into actual practice.

ATTCs sponsor conferences and workshops to expose substance abuse counselors to current research-based practices, offer academic programs and coursework in addiction, provide technical assistance, conduct workforce studies, coordinate leadership activities, develop training curricula and products, and create online courses and classes. The ATTCs also coordinate activities to recruit individuals to enter the addiction treatment field and to develop strategies to help retain the current workforce.

Two useful tools already generated by the ATTCs relating to methamphetamine include Methamphetamine 101 – the Etiology and Physiology of an Epidemic, along with Methamphetamine 102 – Introduction to Evidence-Based Treatments both available at <http://www.psattc.org>.

The CAPTs help SSAs apply evidence-based substance abuse prevention programs, practices and policies in State substance abuse systems. There are five regional CAPTs (Northeast, Southeast, Southwest, Central and Western) that support this important work. As noted by SAMHSA, the CAPT system “is a practical tool to increase the impact of the knowledge and experience that defines what works best in prevention programming.”

Yet another important tool is SAMHSA’s Treatment Improvement Protocols (TIP) series. For methamphetamine use, SAMHSA’s TIP 33, Treatment for Stimulant Disorders, gives substance use disorder treatment providers vital information about the effects of stimulant abuse and dependence, discusses the relevance of these efforts to treating stimulant users, describes treatment approaches that are appropriate and effective, and makes specific recommendations on the practical application of these treatment strategies.

Synthetic Drug Control Strategy: The Synthetic Drug Strategy promotes the identification and sharing of best practices as a top priority. A large emphasis is placed on better information dissemination regarding methamphetamine lab clean ups and environmental issues. As mentioned earlier, ONDCP, DOJ and SAMHSA will collaborate with NAMSDL to sponsor four regional conferences on methamphetamine. We appreciate the inclusion of SSAs as participants – and NASADAD as an observer – at these important meetings. As previously mentioned, NASADAD appreciates the work of SAMHSA in sponsoring two meetings for SSAs to review methamphetamine treatment protocols.

Continue to Support Research: Our current understanding of methamphetamine can be traced to discoveries made possible in large part through federally supported research – including work performed by the *National Institute on Drug Abuse (NIDA)*, led by Dr. Nora Volkow.

NIDA-supported research has led to a greater understanding of the impact of methamphetamine on the brain. In particular, NIDA researchers have discovered that methamphetamine damages nerve terminals in the dopamine-and serotonin-containing regions of the brain. NIDA has also established the Methamphetamine Clinical Trials Group (MCTG) to conduct clinical trials of medications for methamphetamine in States where the drug is particularly popular. Finally, NIDA's research served as the foundation for the Matrix Treatment model, which has been effective in treating methamphetamine dependence.

NASADAD commends NIDA and CSAT for working together to sponsor a series of meetings to focus on how to translate research into every day practice. In particular, these meetings are examining the link between SSAs, NIDA's Clinical Trials Network (CTN) and the ATTCs. In addition to open regional meetings, NIDA and CSAT co-sponsored day-long sessions at NASADAD's Annual Meetings in 2004, 2005 and 2006. The Annual Meeting sessions are designed to (1) provide State substance abuse directors an opportunity to learn more about NIDA's research portfolio and progress of the CTN, (2) promote a discussion between NIDA and SSAs on ways to improve the manner in which evidence-based practices are used in the publicly funded State substance abuse system, and (3) ensure a continued dialogue on the current research portfolio at NIDA pertaining specifically to State addiction systems.

Finally, NASADAD is pleased with NIDA/SAMHSA's Request for Applications (RFA) designed to strengthen SSAs capacity to support and engage in research that will foster Statewide adoption of meritorious science-based policies and practices. These activities will be important tools that will inform our efforts related to prescription drug abuse and methamphetamine.

NASADAD believes Congress should continue its strong support of research at NIDA so that we may learn more about the impact methamphetamine and the potential promise of medication as an adjunct to methamphetamine treatment. NASADAD is concerned with the recent decision of the House Appropriations Committee to cut funding for NIDA by \$5.2 million. As a member of both the Friends of NIDA and Ad Hoc Group for Medical Research, NASADAD supports a five percent increase for NIDA to fulfill its mission.

Synthetic Drug Control Strategy: The Administration notes efforts to "...enhance scientific understanding of effective treatment options for synthetic drug treatment." In particular, the document mentions NIDA's work to research "...the most effective way of treating methamphetamine addiction." The Synthetic Drug Control Strategy also emphasizes the importance of prevention research at NIDA. NASADAD strongly supports NIDA's work to make substance abuse prevention one of the Institute's top priorities.

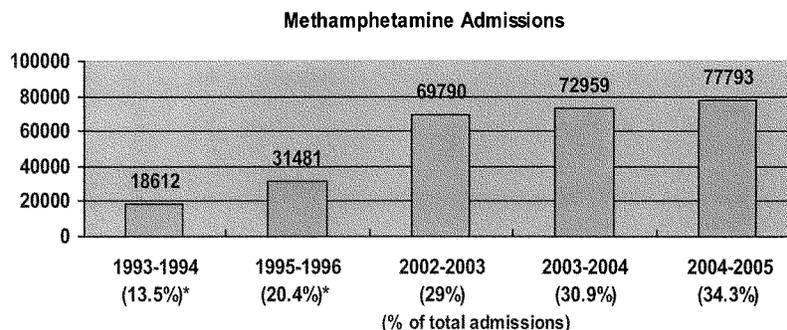
Conclusion: Thank you again for inviting NASADAD to testify. I would be happy to entertain any questions the Committee may have.

NASADAD

ATTACHMENT I

California

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



*Total amphetamines admissions, methamphetamine was not yet reported separately.

Rise in Methamphetamine Admissions

In 1986, drug treatment programs admissions for amphetamines including methamphetamine were 3,853 or 4% of total admissions. Between 1993-94 and 1995-96, there were significant increases in primary amphetamine admissions, from 18,612 (13.5% of total admissions) to 31,481 (20.4% of total admissions). In 2002-2003, the first year that methamphetamine was recorded separately from other amphetamines, there were 69,790 admissions with a primary diagnosis of methamphetamine use (29.0% of total admissions). In 2003-2004 admissions with a primary diagnosis of methamphetamine increased to 72,959 or 30.9% of total admissions. In 2004-2005 admissions with a primary diagnosis of methamphetamine again increased, to 77,793 or 34.3% of total admissions.

Of those in treatment (2004-2005) with Methamphetamine as primary drug at admission:

- 60.3% White
- 35.2% Hispanic
- 4.3% African-American
- 3.2% Asian – PI
- 2.1% Native American
- 11.3% Under the age of 21 years
- 56.9% Male

Impact of Prop 36

In SFY 2001-2002, there was an increase in referrals from the criminal justice system as a result of the Substance Abuse and Crime Prevention Act (**California Proposition 36**) prescribing treatment for first-time, non-violent drug offenders. This change contributed to an increase in primary diagnoses of methamphetamine use, from 21% of admissions to 30.9%.

Other State Activities to Note

- The California State Legislature has established the Senate Select Committee on Methamphetamine Abuse to address the methamphetamine problem in California. Chaired by State Senator Jackie Speier (D-San Francisco/San Mateo), the Committee will provide legislative attention to the State methamphetamine epidemic.
- In 2000, California voters approved the Substance Abuse and Crime Prevention Act (SACPA) which mandates drug treatment instead of incarceration for first or second-time nonviolent adult drug offenders. Recent UCLA evaluations show that 55 percent of clients entering SACPA report methamphetamine as their primary drug of choice. The UCLA cost-benefit analysis of SACPA showed a cost savings for state and local government of \$2.50 for every dollar invested for all SACPA-eligible offenders and \$4.00 for every dollar invested for SACPA participants who completed treatment programs.
- Governor Schwarzenegger's January 2006 budget includes \$120 million in funding for SACPA activities contingent on reforms which will improve outcomes and accountability. The reforms that the Administration seeks include structuring the program after the drug court model, which allows for close judicial monitoring through dedicated court calendars, requires drug testing as a condition of probation and allows for jail sanctions as a tool to encourage clients to enter and continue treatment. The Administration also seeks reforms in SACPA treatment programs which would ensure that programs are culturally competent and tailored to fit the assessed needs of the individual client.

If **additional resources** were made available to improve methamphetamine services, the areas in most need of assistance would be:

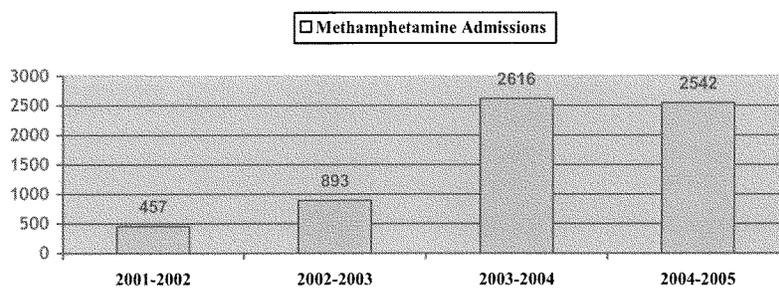
- Increased residential and outpatient treatment capacity
- Increased sober living environments and/or transitional housing
- Creation of both statewide and local cross-jurisdictional collaborations of public and private organizations using an integrated systems approach, with particular emphasis on coordination of public health, child welfare, and law enforcement efforts.
- A statewide public awareness campaign focused on both prevention and recovery
- Expanded Technical Assistance to counties

Kathy Jett, Director
California's Department of Alcohol and Drug Programs

Should you have any questions, or require additional information, please do not hesitate to contact Robert Morrison, Director of Public Policy, at (202) 293-0090 x 106 or email: rmorrison@nasadad.org or Anne Luecke, Public Policy Associate, at (202) 293-0090 x 111 or email: aluecke@nasadad.org.

Florida

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



Florida providers began noticing methamphetamine use in their client population in 2002. Certain areas of the State have shown increased admissions for methamphetamine. The initial area of growth was largely rural and along the western Interstate 10 corridor. In Central Florida, the Interstate 4 corridor from Tampa to Orlando has over 50% of the admissions. Methamphetamine admissions were 2.2% of all admissions for 2004-2005.

2005 Demographics

- 46.9% of Admissions were male
- 56.6% were between the ages 18-32
- 53.1% of Admissions were female
- 12.1% were between the ages 13-17

Other State Activities to Note

The Department of Children and Families (DCF) Substance Abuse Program Office is currently participating actively in two recently formed work groups which were convened to focus on the emerging methamphetamine problem in Florida.

- 1) The Drug Endangered Children workgroup which will have a primary focus on children in welfare affected by methamphetamine with lead coordination responsibility from the Child Welfare and Community- Based Care Program, and
- 2) The Methamphetamine Legislative Workgroup coordinated by the Florida Office of Drug Control.

The Substance Abuse Program Office is working with partners through these two workgroups to define the extent of the problem, identify issues, and to determine strategies to improve methamphetamine prevention, identification and screening, as well as access to treatment for both adults and children.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Recovery support services (child care, transportation, job training)
- Outpatient capacity
- Early Intervention and prevention services in rural areas

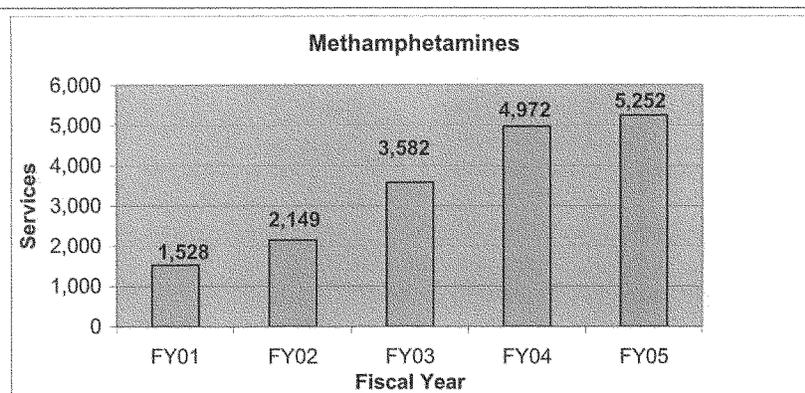
For more information, please contact the Florida Single State Authority for Substance Abuse (SSA):

Stephanie Colston, Director of Substance Abuse
FL Department of Children & Families

Should you have any questions, or require additional information, please do not hesitate to contact Robert Morrison, Director of Public Policy, at (202) 293-0090 x 106 or email rmorrison@nasadad.org or Anne Luecke, Public Policy Associate, at (202) 293-0090 x 111 or email aluecke@nasadad.org.

Illinois

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



In the past five State fiscal years, methamphetamine has shown the largest increase in services of any single primary drug. Total services ranged from just 1,528 in FY2001 to 5,252 in FY2005. This is an increase of more than 243%. Patients from rural counties in central and southern Illinois received 77% of services.

Demographics FY2005

- 97% White
- 54% Male
- Of the 2,404 female, 5% were pregnant
- 31% of services were given to adults between the ages of 18 and 24

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Residential and outpatient capacity
- Wrap-around services

State Action

The Illinois Attorney General sponsors a taskforce on methamphetamine and the Governor has sponsored several public awareness events. A number of community coalitions have formed. The Division of Alcoholism and Substance Abuse will be sponsoring Matrix Model training for Illinois providers to support improved treatment retention and outcomes.

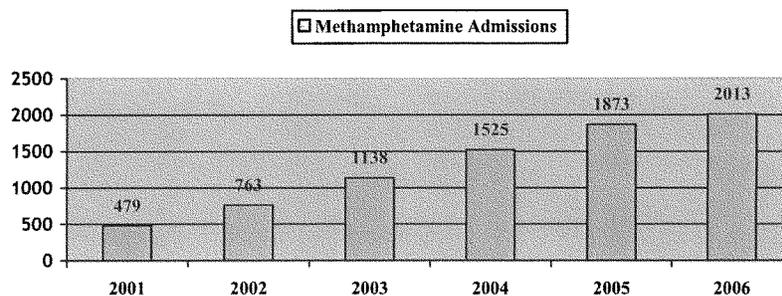
For more information, please contact the Illinois Single State Authority for Substance Abuse (SSA):

Theodora Binion Taylor, Director
Division of Alcoholism & Substance Abuse
Illinois Department of Human Services

Should you have any questions, or require additional information, please do not hesitate to contact Robert Morrison, Director of Public Policy, at (202) 293-0090 x 106 or email: rmorrison@nasadad.org or Anne Luecke, Public Policy Associate, at (202) 293-0090 x 111 or email: aluecke@nasadad.org.

Indiana

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



Indiana providers began to see a significant increase in methamphetamine admissions in 2001. Since then, methamphetamine admissions have increased 291%.

2003 Demographics

- Majority of admissions are White/Caucasian
- 47% Female
- 53% Male
- 40% Between the ages 25-34

Other State Action to Note

Indiana has implemented a restriction on sales of pseudoephedrine and ephedrine; formed the Governor's Methamphetamine Abuse Task Force in 2005; and hosted a Methamphetamine Summit held by the Midwestern Governors Association (MGA) Dec. '06. In addition, the Indiana Single State Authority (SSA) for Substance Abuse is working with the Department of Corrections (DOC) to develop a Memorandum of Understanding (MOU) related to methamphetamine recovery programs to ensure the promotions of best practices for treatment.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Residential and intensive outpatient capacity
- Sharing of best practices
- Wrap around services (child care; transportation, job training, etc).

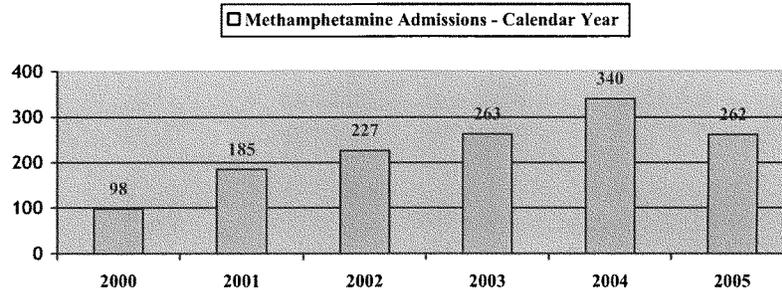
For more information, please contact the Indiana Single State Authority for Substance Abuse (SSA):

John Viernes, Jr., Deputy Director
Division of Mental Health and Addiction,
Indiana Family & Social Services Administration

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Maryland

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot for Methamphetamine



State Fiscal Year 2005 Demographics on Methamphetamine Admissions

- 55.9% White Male
- 22.9% White Female
- 13.0% Black Male
- 5.5% Black Female
- Average age – 31 years old
- Highest percentages of admissions were from Baltimore City (15.1), Baltimore (11.9) and Montgomery (10.7) counties

Treatment Effectiveness Data

For persons discharged from treatment for methamphetamine in SFY 2005, 39% were employed at admission while approximately 48% were employed after discharge – representing an increase of 23%. In the same year, approximately 60% of methamphetamine abusers successfully completed treatment. Fifty-seven percent were using methamphetamines in the month preceding admission, half of them daily; 6 percent used in the month preceding discharge and for 10 percent the level of use was unknown.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Residential capacity

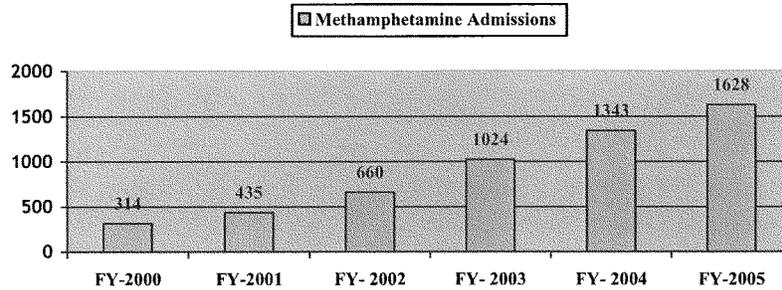
For more information, please contact the Maryland Single State Authority for Substance Abuse (SSA):

Peter F. Luongo, Ph.D., Director
Alcohol & Drug Abuse Administration

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Michigan

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



Michigan providers first detected a noticeable number of methamphetamine-involved admissions in 2001. The reported quantity of these admissions has nearly quadrupled since that time.

Demographics FY 2005

The profile of a typical methamphetamine user in Michigan is: median age of 29, slightly more likely to be male than female (54% to 46%), and predominantly white (94.2%).

Treatment Effectiveness Data

When matching each client's admission to his or her discharge, of the 1,440 methamphetamine-involved cases in FY 2005 that were discharged (detox excluded):

There was a 24.4% reduction in reported homelessness; a 36.7% increase in those reporting either full or part time employment, a 62.3% reduction in the number of arrests. For clients who reported methamphetamine as their primary drug, 69.4 % reported recent use at admission while 24.7% of them reported recent use at discharge (a 64.4% reduction). For methamphetamine as a secondary drug, there was a 68.9% reduction in those using when making the same comparison. When methamphetamine was reported as a tertiary drug, the reduction in use was 73.2%

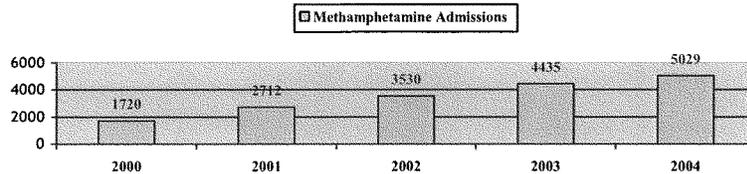
For more information, please contact the Michigan Single State Authority for Substance Abuse (SSA):

Deborah Hollis, Administrator
Division of Substance Abuse and Gambling Services
Office of Drug Control Policy
Michigan Department of Community Health

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Minnesota

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
2006 State Snapshot on Methamphetamine



Minnesota first detected a noticeable number of methamphetamine admissions in 2000. Methamphetamine was the primary substance of abuse in 2% of all admissions in 1996 and 13% of all admissions in 2004.

2004 Demographics

- 93% White
- 42% of all clients receiving treatment for methamphetamine lived in the metro Twin Cities area
- The percentage of clients addicted to methamphetamine was highest around St. Cloud (13%) and lowest in northwestern MN (5%)

Treatment Effectiveness Data

The Minnesota Single State Authority for Substance Abuse (SSA) examined follow up data collected from 1993-1999 from a sample of 99 persons treated for methamphetamine addiction. The data showed that 73% of this sample reported abstinence from any substance 6 months after discharge.

2003-2004 Other Data

- Whereas only 46% of publicly funded clients admitted for alcohol disorders used a secondary substance, 76% of those admitted for methamphetamine disorders used a secondary substance.
- Among publicly funded clients admitted with a secondary substance, the most typical substances that accompany methamphetamine were marijuana (55%) and alcohol (27%).
- The completion rate of those who use methamphetamine only is virtually identical to the completion rate of those who use methamphetamine and other substances.
- Among all clients who completed a span of treatment in 2003, 20% of methamphetamine users were readmitted to treatment by the end of 2004. This percentage is lower than the percentage readmitted for crack and about the same as that for other illegal drugs.

Other State Activities to Note

Minnesota has initiated specific initiatives regarding methamphetamine, including a Governor's initiative which includes bolstered support for prevention and law enforcement efforts.

If **additional resources** were available to improve services, the areas in most need of assistance would be:

- Statewide training in best practices
- Additional support for quality control and monitoring
- Targeted support to close service delivery gap for pregnant and parenting women

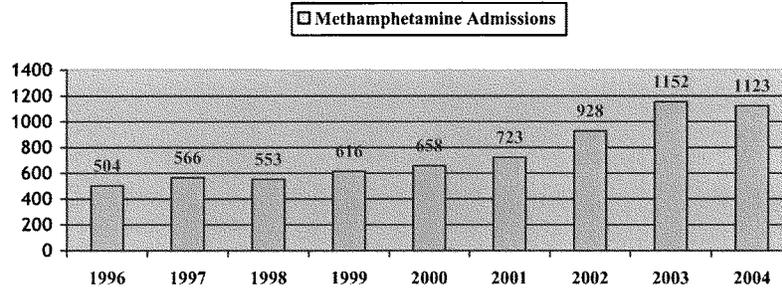
For more information, please contact the Minnesota Single State Authority for Substance Abuse (SSA):

Donald R. Eubanks, Director
Chemical Health Division
Minnesota Department of Human Services

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New York

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



Although the number of admissions with methamphetamine identified as the primary, secondary, or tertiary problem substance is less than 1 percent of all admissions in New York State, there has been a reported increase of over 100 percent in the period from 1996 through 2003.

2004 Demographics on Methamphetamine Admissions

- 75% White
- 11% Hispanic
- 31% Between the ages 25-34
- 31% Female

Location

The number of New York methamphetamine lab “busts” increased dramatically in 2003, with a corresponding increase in the number of admissions in the affected counties. Labs were found almost entirely in the State’s rural areas, especially the southern tier (adjacent to Pennsylvania) and in central New York. Methamphetamine also became popular as a party and sexual experience-enhancing drug among the gay community in Manhattan (New York City). This use, associated with “unsafe sex,” has raised the specter of a new spread of HIV infection and, potentially, broader impact in New York City, with health and social problems similar to those experienced during the crack cocaine epidemic of the late 1980s.

Other State Activities to Note

Under Governor Pataki’s leadership, New York law (Chapter 394) was enacted in 2005 that contained sweeping changes to combat the production and use of methamphetamine.

- ✓ Criminal penalties for possessing manufacturing and precursor materials such as cold tablets, camping fuel, and lithium batteries were enacted.
- ✓ The production of methamphetamines in a residence where children live is now classified as a felony.
- ✓ OASAS is designated as the principle source of information for the statewide dissemination of information on methamphetamine.

Under the law, OASAS is authorized to provide education and training to: the employers of mandated reporters (who must report suspected laboratory activity if children live on the premises), emergency services personnel, child protective services, social services, chemical dependence prevention and treatment providers, school personnel, health care providers, and other interested entities and individuals.

To address its responsibilities, OASAS is employing a three pronged approach:

1. The OASAS Electronic Methamphetamine Clearinghouse – This is a one stop, user friendly website that catalogues and provides a direct link to all the best currently available information and training sources on the dangers of methamphetamine and its production. The Clearinghouse includes an excellent reproducible color pamphlet, entitled “How to Recognize a Clandestine Methamphetamine Laboratory” that is geared to mandated reporters and first responders, detailing the signs of a lab and the steps to take to report it. (<http://www.oasas.state.ny.us/meth/index.htm>)
2. An Interagency Methamphetamine Steering Committee – Comprised of 12 separate state agencies, OASAS has convened this group to bring about a coordinated response to the threat of methamphetamine, by revising protocols and ensuring the delivery of necessary training to their constituent providers. The Steering Committee has been working with the federal Drug Enforcement Agency, the U.S. Attorney General’s Office, SAMHSA’s Center for Substance Abuse Treatment and the New York State Association of Sheriffs on the planning of a statewide Methamphetamine Summit. The Summit will bring together key local law enforcement, health, social services, chemical dependence treatment and prevention providers and other partners with federal and state representatives to formulate a strategic framework for communities to respond to the threat of methamphetamine.
3. OASAS Internal Work Group that is developing and monitoring a plan of action for the delivery of necessary information and training to chemical dependence prevention and treatment providers throughout the State.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- | | |
|---|---|
| <ul style="list-style-type: none"> ➤ Prevention and intervention resources (including media campaigns that incorporate cultural awareness) | <ul style="list-style-type: none"> ➤ Sharing of best practices ➤ Staff training ➤ Wrap Around Services |
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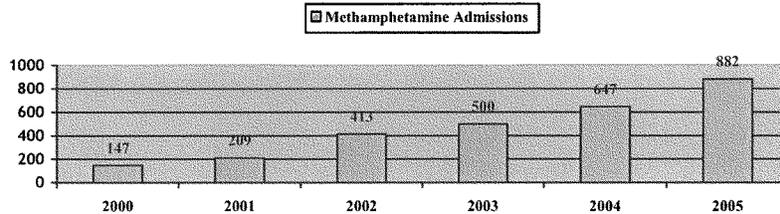
For more information, please contact the New York Single State Authority for Substance Abuse (SSA):

Fran Harding, Associate Commissioner
NYS Office of Alcoholism & Substance Abuse Services

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North Carolina

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



North Carolina providers first detected a rising number of methamphetamine admissions in 2002.

2005 Demographics on Methamphetamine Admissions

- 91.50% White
- 3.17% Black
- 46.71% Female / 53.29% Male
- 42.52% Between ages 25-34

Other State Activities to Note

North Carolina has a special methamphetamine treatment initiative focused on some of the State's western counties hardest hit by methamphetamine use. The State also passed tougher laws related to methamphetamine production, sales and distribution. The North Carolina Legislature signed into law a measure that restricts the sale of Sudafed and other cold medicines in an effort to stop the cooking of the illegal drug methamphetamine. Under the new law, buyers have to go to a pharmacy counter, show identification and sign a log in order to buy any tablets containing pseudoephedrine and ephedrine. Buyers also must be at least 18 years old. They cannot purchase more than two packages at a time, and no more than three within 30 days without a prescription. Stores without pharmacies, such as convenience stores and some groceries, are not able to sell the medications at all. Legislation also included more aggressive prosecution for those exposing methamphetamine to children. Finally, standards have been put into place for removing toxic residue from residences that house methamphetamine labs.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Wrap-around services
- Residential capacity
- Staff training

For more information, please contact the North Carolina Single State Authority for Substance Abuse (SSA):

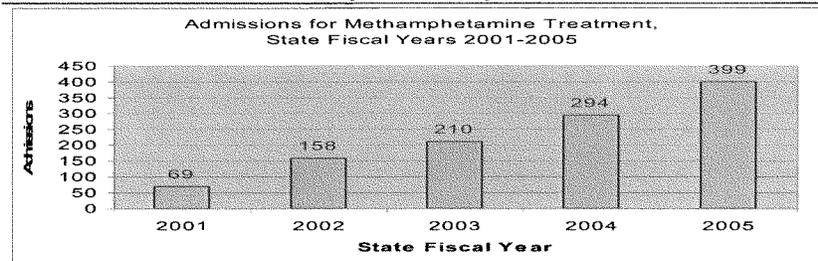
Flo Stein, Chief

Division of Mental Health, Developmental Disabilities & Substance Abuse Services
North Carolina Department of Health & Human Services

Should you have any questions, or require additional information, please do not hesitate to contact Robert Morrison, Director of Public Policy, at (202) 293-0090 x 106 or email: rmorrison@nasadad.org or Anne Luecke, Public Policy Associate, at (202) 293-0090 x 111 or email: aluecke@nasadad.org.

Ohio

2006 National Association of State Alcohol and Drug Abuse Directors
State Snapshot on Methamphetamine



Admissions in Ohio's publicly funded substance abuse treatment system for clients with an identified primary drug of choice of methamphetamine rose from 69 in SFY 2001 to 399 in SFY 2005. First reports about increases in methamphetamine production and abuse were obtained from the Akron area in 2000. Starting in 2002, most areas were consistently reporting small increases in methamphetamine availability.

Demographics

Ohio has seen a trend emerging in the characteristics of users. Providers and users identify two groups of users: a) poor whites who are using low quality, locally made methamphetamine; and b) young white adults who are using higher quality methamphetamine at rave parties.

There also appears to be a trend of increased use among females. In SFY 2001, 60.9% of users were male and 39.1% were female. By SFY 2005 the percentage of men to women was 50.1% to 49.9%. During the same timeframe, the majority of users were consistently young adults aged 18 - 34.

Method of Administration

Smoking and inhaling methamphetamine continue to be the most common method of administration. However, active users of high quality methamphetamine reported oral administration ("capping") is increasingly common among those who prefer a "controlled" high. In the current reporting period, active methamphetamine users from the Dayton and Columbus areas also describe a method of administration called "hot railing," which involves inhaling crystal methamphetamine through the nose as it vaporizes while passing through a heated glass pipe.

If **additional resources** were available to improve services, the areas in most need of assistance would be:

- Staff training
- Sharing of best practices

State Action

The Ohio Department of Alcohol and Drug Abuse Services (ODADAS) has convened a workgroup to develop a summary on the current methamphetamine problem in Ohio with recommendations for prevention, treatment, legislative and enforcement action. Also, in 2003 a State Methamphetamine Summit was conducted. Summit participants came to learn as much as possible about methamphetamine, and to develop a working relationship with interested parties outside their own disciplines.

For more information, please contact the Ohio Single State Authority for Substance Abuse (SSA):

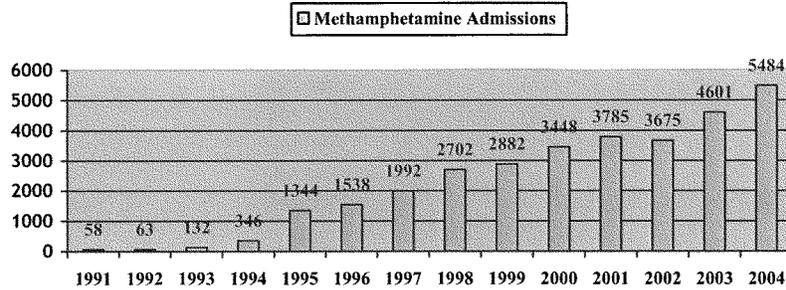
Carolyn Givens, Director

Ohio Department of Alcohol & Drug Addiction Services

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Utah

2006 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Snapshot on Methamphetamine



A significant increase in the number of admissions for methamphetamine occurred in SFY 1995.

2004 Demographics on Methamphetamine Admissions

- 88% White
- 51% Male
- 40.6% Between ages 25-34
- 49% Female

Treatment Effectiveness Data

The division reported that in State Fiscal Year 2004, 60.8% of methamphetamine clients were abstinent at discharge.

Other State Activities to Note

- Created the Salt Lake City Methamphetamine Task Force.
- Utah developed two women's treatment programs in collaboration with local authority providers.

If **additional resources** were made available to improve services, the areas in most need of assistance would be:

- Residential and outpatient capacity
- Sharing of best practices
- Wrap-around services
- Staff training

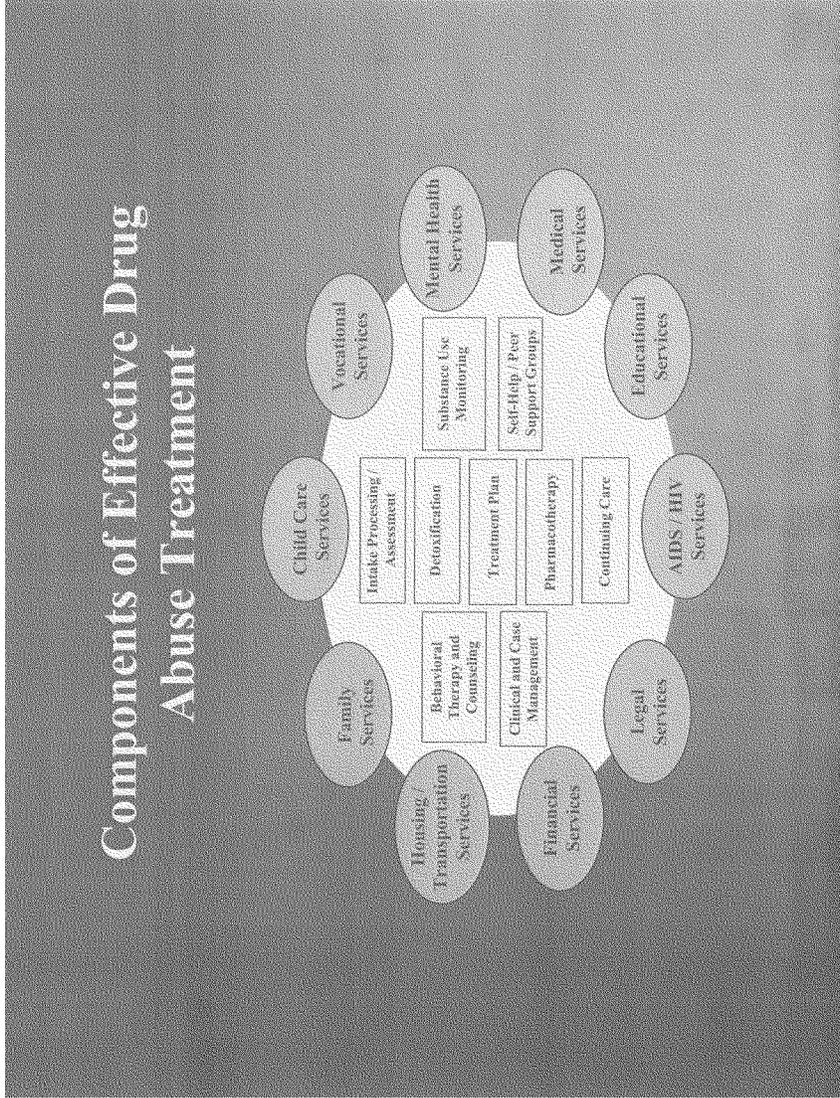
For more information, please contact the Utah Single State Authority for Substance Abuse (SSA):

Mark Payne, Director
Division of Substance Abuse and Mental Health
Department of Human Services

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NASADAD

ATTACHMENT II



NASADAD

ATTACHMENT III

**Substance Abuse Prevention and Treatment (SAPT)
Produces Positive Outcomes –
State Examples**

Alaska's Division of Behavioral Health reported 5,400 admissions to treatment in State Fiscal Year 2005 and provided prevention services to 2,000 individuals. The most recent outcomes study to measure the effectiveness of Alaska's publicly funded treatment system found that of the patients surveyed one year after treatment, 56 percent of those in outpatient programs abstained from alcohol and 75 percent of the residential patients participating in year-long aftercare programs were abstinent.

California's Department of Alcohol and Drug Programs reported 226,712 admissions to treatment and provided prevention services (both recurring and one-time) to over 3 million individuals in State Fiscal Year 2004/2005. The California Drug and Alcohol Treatment Assessment (CALDATA) study in 2002 found the cost of treating a sample size of approximately 150,000 individuals in 1992 was \$209 million – while the benefits were approximately \$1.5 billion in savings in large part through reductions in crime.

Colorado's Alcohol and Drug Abuse Division (ADAD) reported 65,949 admissions to treatment in FY 2005 (an 18 percent increase over the previous year) and provided prevention services to 66,225 persons. Colorado noted that in 2005, 81 percent of methamphetamine users were abstinent at discharge. For prevention, there were statistically significant reductions in 30 day past use of cigarettes, alcohol, inhalants and cocaine for youth ages 12 to 17.

Florida's Department of Children and Families reported 52,663 treatment admissions in State Fiscal Year 2004-2005. In SFY 2004-2005, 68 percent of adult clients were abstinent one year after discharge; 55 percent of child clients were abstinent one year after discharge; there was a 30 percent decrease in homelessness for clients receiving treatment; and employment rates increased by 19 percent for clients receiving treatment.

Hawaii's Division of Alcohol and Drug Abuse reported 3,851 treatment admissions in State Fiscal Year 2005 and provided recurring prevention services to 3,590 individuals and one-time prevention services to 83,331 individuals. The Division noted the following outcomes for a sample of 567 adults six months after treatment: 57.3 percent cited no substance use since discharge from treatment; 71.3 percent were not arrested since discharge; and 74.4 percent were not hospitalized since discharge.

Illinois' Division of Alcoholism & Substance Abuse reported 79,054 admissions to treatment and provided prevention services to 346,170 in State Fiscal Year 2005. In State Fiscal Year 2004, client outcomes data comparing admission and discharge showed increased rates of abstinence from alcohol and other drugs.

Iowa's Division of Behavioral Health and Professional Licensure reported 42,025 admissions to treatment and provided prevention services to approximately 214,216 individuals in State Fiscal Year 2005. Iowa's 2005 Outcomes Monitoring System found

the following regarding methamphetamine clients six months after being discharged from treatment: 65.4 percent were abstinent; 89.2 percent had not been arrested; and the percentage of those employed full time increased by 14.3 percent.

The Kansas Addiction and Prevention Services (AAPS) Program reported that 15,622 persons were admitted into treatment services and 81,677 persons were provided prevention services during the State Fiscal Year 2005. For SFY 2005, the following client outcomes were reported comparing admission to discharge: 90 percent of consumers reported abstinence at discharge, and 50 percent of the persons who were admitted for services changed from being homeless to having a place to live.

Kentucky's Office of Drug Control Policy reported 26,107 admissions to treatment in State Fiscal Year 2003. A 2003 Kentucky outcomes report found the following regarding a sample of over 1,000 clients one year after treatment: 67.6 percent reported abstinence from alcohol; 71 percent reported abstinence from illegal drugs; 85.3 percent were abstinent from marijuana; and there was a 48.6 percent increase in the percentage of clients employed.

Louisiana's Office of Addictive Disorders (OAD) reported 32,607 admissions to treatment in State Fiscal Year 2005. For SFY 2005, the following client outcomes were reported comparing admission and discharge: 82 percent decrease in the number of clients arrested; 13 percent increase in the number of clients employed full time; 10 percent increase in the number of clients employed part time; and a 61 percent decrease in primary drug use from admission to discharge.

Maryland's Alcohol and Drug Abuse Administration (ADAA) reported 47,555 admissions to treatment and provided prevention services to 301,213 individuals through 540 recurring prevention programs. In 2004, ADAA found that arrests decreased during treatment by as much as 85 percent depending on the level of care; the percentage of clients employed increased eight-fold during half-way house treatment; and overall homelessness decreased during treatment.

Michigan's Division of Community Services and Gambling reported 64,697 admissions to treatment and provided prevention services to 150,458 individuals in State Fiscal Year 2005. In a 2004, the following client outcomes were reported comparing admission to discharge: 75.9 percent reported zero use; there was a 49.4 percent reduction in homelessness; 84.6 percent retained their job; and 72.2 percent with a recent arrest prior to admission reported no arrests.

Minnesota's Division of Chemical Health reported 23,098 admissions to treatment in Calendar Year 2004. In examining outcomes data for clients admitted to treatment between 1993 and 1999, 54 percent of respondents reported no use of substances six months after treatment. Within this sample, 73 percent of persons addicted to methamphetamine reported abstinence from any drug use six months after treatment.

Montana's Bureau of Addictive and Mental Disorders reported 6,674 admissions to treatment in State Fiscal Year 2005. In SFY 2005, the Bureau reported the following outcomes of a sample of 1,336 clients six months after discharge: 72.5 percent reported no use of substances; employment status increased by 20 percent; and 94.5 percent of clients had no probation or parole violations.

Nevada's Bureau of Alcohol and Drug Abuse (BADA) reported 11,189 admissions to treatment and provided prevention services to 12,144 individuals in State Fiscal Year 2005. In State Fiscal Year 2005, the following client outcomes were reported for those completing treatment: 90.4 percent were abstinent at discharge.

New Jersey's Division of Addiction Services (NJDas) recorded 54,404 admissions to substance abuse treatment in CY2005. In CY2005, NJDas reported the following client outcomes comparing admission to discharge: 95% decrease in those who are using alcohol, 77% decrease in those using heroin, 81% decrease in those using cocaine, 90% decrease in those using marijuana, a 33% reduction in those who are homeless, and a 62% reduction in arrests.

New York's Office of Alcoholism and Substance Abuse Services (OASAS) reported 113,730 admissions to treatment in FY 2003. OASAS reported the following client outcomes in FY 2003: 50.5 percent increase in the number of patients abstinent from alcohol; 72.7 percent increase in the number of patients abstinent from other drug use; 25.9 percent increase in the number of patients employed; 33.6 percent decrease in the number of patients who were homeless; and 60.3 percent decrease in the number of patients arrested in the past month.

North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services reported 33,048 admissions to treatment in State Fiscal Year 2003-2004. One sample study of publicly funded clients showed the following outcomes: a decrease in any alcohol use from 71 percent to 10 percent; a decrease in marijuana use from 45 percent to 5 percent; a decrease in cocaine use from 32 percent to 2 percent; a decrease in arrests from 20 percent to 2 percent; and increase in full-time employment from 49.8 percent to 59.3 percent.

Ohio's Department of Alcohol and Drug Addiction Services (ODADAS) reported 89,389 admissions to treatment in State Fiscal Year 2004. ODADAS noted in the following cost savings achieved in SFY 2004: women in treatment gave birth to 588 drug-free babies in 2004 saving \$29.5 million in health care costs; of unemployed Ohioans in treatment, approximately 1,000 obtained employment during treatment to generate \$16.6 million in earnings (at \$8 per hour) and a combined State and local tax gain of \$2.9 million; and substance abuse prevention services saved \$165.3 million.

Pennsylvania's Bureau of Drug and Alcohol Programs reported 92,224 admissions to treatment and provided prevention services to 111,145 individuals in State Fiscal Year 2004/2005. In SFY 2004-2005, the Bureau reported the following client outcomes comparing admission to discharge: 77 percent of clients addicted to alcohol were

abstinent; 71 percent of clients addicted to cocaine/crack were abstinent; 75 percent of clients addicted to marijuana were abstinent; and 65 percent of clients addicted to heroin were abstinent at discharge.

South Carolina's Department of Alcohol and Other Drug Abuse Services (DAODAS) reported 29,843 admissions to treatment in State Fiscal Year 2005. In SFY 2005, the Department reported the following client outcomes from a sample survey comparing admission to 90 days after discharge: 73.2 percent of clients reported no alcohol use; 77.2 percent of clients reported that they were employed; and 94.1 percent of students reported a reduction in suspensions, expulsions or detention.

South Dakota's Division of Alcohol and Drug Abuse reported 16,394 admissions to treatment in FY 2005. A study released in FY 2005 on 5,161 indigent clients receiving addiction services between April 1999 and November 2004 found that approximately half were abstinent one year after discharge. A 2003 analysis that found methamphetamine clients experienced fewer arrests after treatment compared to 12 months before admission in the following categories: driving while intoxicated, disorderly conduct, assault or battery, theft, possession of drugs, and sale of drugs. Before treatment, nearly two-thirds of methamphetamine clients had been jailed overnight, but this rate declined to 10.8 percent for those who remained abstinent one year post treatment.

Tennessee's Bureau of Alcohol and Drug Abuse Services reported 15,168 admissions to treatment in FY 2004. The Bureau reported in a 2003 study that over 65 percent of methamphetamine clients were abstinent six months after discharge. A study of 2,000 clients receiving publicly funded services in 2003 found the following client outcomes comparing admission to six months after admission: 65.1 percent were abstinent; unemployment declined from 60.7 percent to 34.3 percent; full-time employment almost tripled, from 15.7 percent to 44.7 percent; and arrests dropped from 55.5 percent to 10 percent.

The Texas Department of State Health Services reported 55,947 admissions to treatment in State Fiscal Year 2005 and provided prevention services to approximately 145,000 persons. The Department reported the following client outcomes comparing admission to 60 days after discharge in 2005: 78 percent of clients addicted to alcohol were abstinent; 75 percent of clients addicted to illicit drugs were abstinent; and homelessness decreased by 69 percent. Client data from 2001 through 2004 show that 88 percent of methamphetamine users were abstinent 60 days after discharge.

Vermont's Division of Alcohol and Drug Abuse Programs reported 8,880 total admissions into the treatment system in FFY 2005. A study of substance abuse treatment and district court data showed a decrease in criminal justice involvement of 28 percent between the rate at which treatment clients were charged with a crime in the three months prior to treatment period and the three months after the treatment period.

Virginia's Department of Mental Health, Mental Retardation and Substance Abuse Services reported 71,020 admissions to treatment in SFY 2005. Consumer data

comparing admission and discharge data showed increased abstinence for alcohol and other drugs and increased employment.

Utah's Division of Substance Abuse and Mental Health reported 18,985 admissions to treatment in FY 2005. The Division reported the following client outcomes in FY 2005 comparing admission to discharge: 74 percent reported no drug use; there was a 14 percent increase in the number of clients employed; and 78 percent were arrest free. In SFY 2004, 60.8 percent of methamphetamine clients were abstinent at discharge.

Washington State's Division of Alcohol and Substance Abuse reported 42,848 admissions to treatment and provided prevention services to 98,129 individuals in State Fiscal Year 2005. A study of over 500 publicly funded clients found a 94 percent increase employment rates between admission and six months post discharge – and average monthly income increased 257 percent – from \$159 at admission to \$568 six months after discharge. Washington State also found that illegal activity declined 85 percent in a study of 600 adults discharged from publicly funded addiction treatment.

West Virginia's Division on Alcoholism and Drug Abuse (DADA) reported 12,968 unduplicated admissions for treatment services and provided prevention services to 33,803 persons through SAPT Block Grant funding. In 2005, DADA reported the following client outcomes comparing admission to 30 days post discharge: a decrease in homelessness and significant increase in abstinence. DADA reported presenting 194 evidenced-based programs to various professionals in the State using a “train-the-trainer” approach.

Wisconsin's Division of Disability, Elder Services, Substance Abuse and Mental Health reported 24,770 admissions to treatment in 2004. A 2002 study of 400 clients found 62 percent successfully completed treatment; 90 percent were satisfied with services; and 55 percent were abstinent six months after discharge. A 2002 study of 410 women estimated that 66 percent were abstinent one year after admission, and the arrest rate went from 49 percent before admission to 16 percent in the year after admission. A 2005 study of 130 adolescents showed that 71 percent were abstinent at discharge.

Mr. SOUDER. Ms. Green.

STATEMENT OF SHERRY GREEN

Ms. GREEN. Chairman Souder, Ranking Member Cummings, Congresswoman Watson and staff, my name is Sherry Green, and I want to thank you very much for this opportunity on behalf of the National Alliance for Model State Drug Laws to testify regarding the recently released Synthetic Drug Control Strategy plan.

I also want to take a few moments to thank Members of Congress, particularly this committee, for your strong role in working with State and locals on addressing synthetic drug issues.

As you may know, my organization works with States to strengthen their drug and alcohol laws to create a more comprehensive, coordinated and efficient continuum of drug and alcohol services throughout the State. We work with State and local professionals on over 40 different drug and alcohol issues. Over the last 2 years, the overwhelming majority of requests that we have received for legislative and policy assistance are unquestionably on the issues of methamphetamine and prescription and drug addiction and diversion issues as well.

Based on our legislative and policy work I offer the following comments on the strategy: We do appreciate the fact that the strategy actually recognizes the leadership role of States in enacting measures to reduce and restrict over-the-counter purchases and sales of pseudoephedrine products. Despite this recognition, however, I see no description of an ongoing mechanism to gather the valuable input of these recognized leaders. So, apparently, under this strategy, it is OK for State and local leaders to play a strong leadership role when that means doing the hard work of creating and implementing solutions to drug and alcohol problems, but it does not mean that they should take a strong leadership role in developing a national strategy.

Moreover, these recognized State and local leaders had to accomplish their gains in over-the-counter restrictions without the benefit of any comprehensive national and compiled data on methamphetamine, including the cost related to methamphetamines laboratories.

State and locals have repeatedly requested the need and expressed the need for a national mechanism which would collect available methamphetamine information, organize it in a cogent manner, indicate the policy implications of that particular information and disseminate the information to State legislatures and other policymakers in a timely manner so they can use the information to make informed, educated decisions. Nothing in the strategy suggests a response to this need for comprehensive, coordinated data at a national level.

Despite our great disappointment over this obvious gap, we are somewhat encouraged the strategy at least mentions treatment and prevention. However, the strategy right up front admits there is a common misperception about the fact that methamphetamine addiction can be treated. Based on our experience, the very people who hold that misperception are State legislators and other policymakers who are charged with making funding, policy and pro-

grammatic decisions. But I see nothing in the strategy that offers proactive options for actually correcting this perception.

From our experience, the failure to actually aggressively address this gap in knowledge leads to a further misperception that there is no current understanding of what works in terms of treating methamphetamine addiction. So we have found in our work certain State and local policymakers who are actually more inclined to try to put scarce resources in their State toward researching what we already know, rather than providing direct services.

So it is our sincere hope that our Federal colleagues will actually try to address these gaps that I have mentioned; and I would tell you that it is also our overall hope that, in terms of any strategy that the Federal Government puts together on synthetic drugs, that it becomes more than just 63 or 53 pages of lip service. We are not going to know if we are actually going to actualize that hope until we actually see a demonstrated commitment to turning those principles and ideas into action plans.

In closing, I would just like to thank my colleagues on the panel for their generosity and their hard work at the State and local level, because they have allowed us to coordinate with them so that our work can actually reflect the valuable experience and expertise of their constituents. And of course at the appropriate time I am more than happy to answer any questions that you might have. Thank you.

Mr. SOUDER. Thank you.

[The prepared statement of Ms. Green follows:]

**Statement of Sherry Green, Esq.,
Executive Director of the National Alliance for Model State Drug Laws (NAMSDL)
before the
House Subcommittee on Criminal Justice, Drug Policy, and Human Resources,
Committee on Government Reform**

**Oversight Hearing on “The National Synthetic Drug Control Strategy”
June 16, 2006**

Chairman Souder, Ranking Member Cummings, members of the Committee, and staff, thank you for this opportunity to appear before you today on behalf of the National Alliance for Model State Drug Laws (NAMSDL) to offer my perspective on the recently released *Synthetic Drug Control Strategy* as it relates to states’ legislative efforts to address methamphetamine (meth), the corollary issues of meth, states’ work to establish prescription drug monitoring programs (PDMPs) as tools to assist in addressing the nonmedical use of prescription drugs, and the expressed needs of states as shared with me and the NAMSDL staff in our work with states on these and other alcohol and other drug related legislative and policy issues. I am honored to be here to discuss these issues and to respond to any questions that you may have.

About the National Alliance for Model State Drug Laws

As you may know, the National Alliance for Model State Drug Laws (NAMSDL) is the successor of the President’s Commission on Model State Drug Laws, appointed by President George H. W. Bush. At the conclusion of the Commission’s work of crafting the 44 model state drug laws addressing over 70 alcohol and other drug issues, the Commissioners created a 501(c)(3) nonprofit organization to serve as an ongoing, bipartisan, independently operated resource to assist states in assessing needs, strategizing, and implementing laws and policies to address alcohol and other drug problems using the model laws as a menu of options. Congress began funding NAMSDL in fiscal year 1995 to hold state model drug laws summits to serve as needs assessment and action planning mechanisms and to provide technical assistance to states as they implement summit recommendations including elements of the models and address emerging issues related to alcohol and other drugs. NAMSDL’s Congressional appropriations also allow the organization to provide technical assistance to states as they consider legislative and policy priorities related to alcohol and other drugs, including drafting, feedback on bills, regional analysis, and collections of existing statutes from other states.

In 2003, NAMSDL accepted a grant from the Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA) to serve as the technical assistance provider for states under the Harold Rogers Prescription Drug Monitoring Program, a competitive grant program currently administered by BJA to assist states in their efforts to plan, establish, and enhance prescription drug monitoring programs (PDMPs). While this is an issue on which NAMSDL has assisted states since the organization’s inception, this dedicated

funding allows NAMSDL to provide states with more intensive assistance and to coordinate information related to these programs.

NAMSDL's Work with States to Address Meth and Its Related Issues Nonmedical Use of Prescription Drugs

During the past two years, requests for information and assistance coming into NAMSDL have been overwhelmingly focused on meth and its related issues. While other alcohol and other drug-related technical assistance requests were received and fulfilled by NAMSDL, meth was by far the highest legislative priority in the substance abuse arena for states. Requests for assistance with meth-related legislation reached such a volume at NAMSDL that the organization has convened two national methamphetamine legislative and policy conferences (2004 and 2005) in an effort to most efficiently and effectively address and accommodate the needs of states in this arena. Since the inception of NAMSDL in 1993, I have rarely seen – without a federal mandate or funding incentive – this number of states pursue legislation simultaneously to address a drug-related issue as occurred regarding methamphetamine.

A clear yet not distant runner-up to meth among the issues on which NAMSDL assisted states was prescription drug diversion, misuse, abuse, and addiction – specifically states' efforts to establish PDMPs as tools to assist in addressing the nonmedical use of these controlled substances. Under the aforementioned grant from BJA, NAMSDL has convened three national conferences on PMPs (2003, 2004, 2006) to provide legislative and programmatic information to states to facilitate the implementation and enhancement of these programs.

A number of state officials and those working with them to draft legislation to address meth and its related issues and PDMPs have indicated that NAMSDL is *the* resource nationally on which they rely for assistance in these areas, including sample statutory language, feedback on draft bills, and synthesis of legislative efforts nationwide and/or in their region. It is from NAMSDL's perspective in working with states in these capacities and in volume that I offer the following observations regarding states' efforts to address meth and prescription drugs as well as related thoughts regarding the strategy. Where I discuss points of concern regarding the strategy, I offer this feedback with the hope that these issues may be incorporated into the agencies' plans as they work with, partner with, share with, encourage and support state and local efforts as they note as their intent through the strategy.

States have led the way re: legislation to address access to precursor chemicals for meth

I appreciate the strategy's recognition of the states' leadership in enacting measures to restrict over-the-counter (OTC) purchases and sales of pseudoephedrine products. As the document also acknowledges, states' efforts to control access to precursor chemicals for meth by regulating sales of OTC pseudoephedrine products appear to have resulted in a reduction in the number of domestic small toxic labs as well as an apparent decline in the

percentage of available meth that is produced by these domestic labs. To date, forty-two states have some measure in place to restrict access to pseudoephedrine products while safeguarding their use for licit purposes. States' legislative efforts to address the purchases of products containing pseudoephedrine reflect four general categories of restrictions: 1) restrictions on the display or offer of the product for sale – including but not limited to scheduling pseudoephedrine, 2) restrictions on who can sell/transfer and/or who can purchase the products, and the requirement to maintain a log/record of the transaction, 3) restrictions on the quantity of a product that can be sold/transferred or purchased within a specified timeframe, and 4) restrictions on packaging of the products. These legislative/regulatory efforts often include exemptions/exceptions to restrictions on the over-the-counter sales/transfer or purchases of pseudoephedrine products in an effort to balance, as the strategy suggests, "law enforcement needs with the need for legitimate consumer access to cold remedies" (p. 22). An overview prepared by NAMSDDL of states' efforts to address pseudoephedrine products has been submitted with my testimony for the record.

States are likely to be interested in the outcomes of the National Institute of Justice's (NIJ) 18-month study of the effectiveness of states' restrictions on pseudoephedrine products that the strategy describes, as the results could assist in efforts to refine their existing legislation. However, this information may not necessarily be the most germane to states' new legislative needs as they are now prioritizing the implementation of additional restrictions on the supply of pseudoephedrine and other precursors in their states, such as considering wholesale and manufacturing provisions. With approximately 80% of states having some measure to address pseudoephedrine in place, states may not necessarily need the Administration's assistance legislatively on the issue of access to OTC pseudoephedrine products.

The strategy fails to specifically acknowledge the range of legislative initiatives that states are using to monitor the flow of precursor chemicals to prevent diversion for the illegal manufacture of methamphetamine. OTC restrictions are only one type of measure that states are developing to trace chemicals at the retail, wholesale and manufacturing levels. For example, states have enacted registration requirements for wholesalers. Washington has gone one step further and limited the quantity of pseudoephedrine products that wholesalers may sell if the total monthly sales of the products within that state exceed a specific percentage of the total prior monthly sales of nonprescription drugs to persons within the state. Legislative efforts such as these have likely contributed to the decrease in domestic meth labs, yet will likely not be part of the outcomes study described in the strategy. Further, these initiatives have not yet been acknowledged or encouraged by the relevant Administration agencies.

Additionally, states have needed to tailor restrictions to meet the specific issues they were experiencing related to meth. For example, Maine enacted restrictions on pseudoephedrine products in an effort to prevent domestic meth labs from becoming a significant problem in the state. Therefore, the national study may or may not find the state's legislation to be as "effective" as other states given the parameters set in the study. However, Maine's law may meet the intended goal and need that the state had in

pursuing the legislation. While the NIJ study will be of interest, it will likely not reflect the overall success of states' efforts.

The strategy references states' efforts to establish tracking systems for OTC purchases and sales of pseudoephedrine products. However, states will struggle to implement these given the ongoing funding challenges, including cuts proposed in the President's Fiscal Year 2007 budget. A commitment of resources to support these touted efforts by states is needed for them to be realized.

States were able to enact these measures to address meth's precursors without 1) the benefit of the Office of National Drug Control Policy (ONDCP) officials testifying to the national priority on meth-related problems – as they have on other substance abuse issues in the states, 2) national data – save for meth lab incident numbers from the El Paso Intelligence Center (EPIC), which, as the strategy alludes, are often not a complete picture, leaving states to rely on their own data collection, or 3) a stable understanding of funding available to support corollary efforts related to meth given the Administration's recent budget proposals that offered reductions and eliminations to funding sources for state and local drug efforts. Based on states' success with these legislative efforts absent Administration support, it is unclear from the strategy how its future involvement may be relevant.

Cleanup and Remediation of Former Meth Lab Sites

From this strategy, the Administration agencies now appear to recognize that the federal government should undertake research to develop and support health-based guidelines for remediating meth labs. This is a need that the Congress acknowledged through the House's passage of HR798 and the Senate's current consideration of S2019. States, once again, are also leaders in this arena. Through legislation and regulation, a growing number of states are addressing the cleanup and remediation of former meth lab sites, given these sites were increasingly residential (e.g. houses, apartments, mobile homes, and other habitable sites). An overview prepared by NAMSDL of states' legislative/regulatory efforts in this area has been submitted with my testimony for the record.

States are addressing issues such as the regulation of cleanup and remediation contractors, notice to potential buyers of former meth lab properties, and supplemental funding for the cleanup and remediation of these sites. Thirteen states have established decontamination standards for meth lab cleanup and remediation. These standards are feasibility-based rather than health-based, which many acknowledge would be the ideal. However, the current lack of research into the short and long term effects related to the production of meth precludes setting health-based standards. Many states are utilizing the regulation and guideline process rather than legislation to address cleanup and remediation, as these measures are more easily changed to match emerging science should research in this area expand. The strategy acknowledges the need for this research and the subsequent development of cleanup and remediation standards based on scientific findings. Toward that end, the strategy's discussion of cleanup and remediation echoes

HR 798 and S2019. States concur with this need for additional research and applaud Congress' pursuit of it this session.

Despite recognizing the importance of addressing cleanup and remediation needs, the strategy lacks specific steps to proactively provide state and local policymakers with relevant information on cleanup and remediation issues for their current work, such as existing applicable research and its policy implications, and existing options for funding cleanup and remediation. States need this type of tangible information to support their existing and ongoing efforts.

Multidisciplinary Coordination of Drug Endangered Children Efforts

Efforts to address drug endangered children (DEC) remain high among states' legislative and policy priorities. States' legislative efforts to address DEC have largely fallen into three categories: 1) increasing penalties for certain activities which occur in the presence of children, 2) increasing penalties but also defining prohibited activity as child endangerment, neglect, or abuse, and 3) emergency or exigent circumstances, e.g. if a responder can immediately remove child from a lab without first obtaining a court order and take child to child protection services or other safe location. An overview prepared by NAMSDL of states' efforts to address DEC issues has been submitted with my testimony for the record.

From a policy and practice standpoint, states are working to coordinate agencies' services that are relevant to children's safety and welfare as they are found at meth lab sites and/or in drug effected homes, such as law enforcement, medical services, child protective services, and social services. Training is an important component of best serving the needs of these children, as the strategy indicates; this must be provided across a range of disciplines and services then coordinated among the relevant state agencies. While initial federal resources addressing DEC were made available for and through law enforcement, states acknowledge that this is a multidisciplinary problem needing coordinated, multidisciplinary responses.

States' Focus on Prevention and Treatment Options

While I am encouraged that the strategy includes prevention and treatment as part of its scope, I am concerned that the commitments made by the agencies will not meet the states' current level of focus on demand reduction. With states' domestic meth lab numbers currently on the decline, state officials and decision makers have prevention and treatment options high among their legislative and policy priorities. NAMSDL has experienced a notable increase in states' requests for this type of assistance. Additionally, meth presents an interesting prevention scenario, given that the demographic with the highest rates of meth use is older, not the youth to whom most prevention programming is directed. While the strategy acknowledges this demographic and also understandably focuses on efforts to prevent meth use among youth, it does not commit to action or offer to states assistance in addressing the adult, working population that is vulnerable to meth use. Further, the strategy does not describe specific prevention

options available to states, including replicable programs touted by Administration officials, such as the Oregon Partnership and the Montana Meth Project.

A growing number of states are using the predominance of meth-related efforts as an opportunity to examine and expand - as resources allow - its addiction treatment services. Historically due to high demand and less than adequate funding, states have not been able to meet the needs for addiction treatment. Waiting lists are a long standing reality. While the strategy indicates support for treatment, it does not clearly acknowledge the need to expand treatment resources. For example, the strategy references the President's request for "a significant increase in support to states for drug courts" (p. 26), which are useful mechanisms for getting individuals assessed for and referred to addiction treatment. However, drug courts are not, in and of themselves, drug treatment and are often as effective as the addiction treatment options to which their participants are referred. Therefore, there remains an inferred gap between needs and resources in the strategy.

Given the unmet treatment needs in states throughout the country, addiction treatment clinicians have also indicated to NAMSDDL that while ongoing research into effectiveness of protocols is important to providing the best services possible, they are cautious against, if you will, "robbing Peter to pay Paul." Meth is not a new drug and is not new to addiction treatment professionals. The field has been successfully treating individuals addicted to drugs including meth for over 30 years when meth arguably first emerged as "crank." While additional research regarding effectiveness is unquestionably beneficial, there is concern that critical dollars are being spent to research some of what is already known in the field - if meth addiction can be treated and how - rather than spent to provide additional direct services to those presenting for treatment. The emphasis of the strategy's treatment portion provides reason to remain concerned about this allocation of federal resources.

Further, the strategy does not include specific proactive steps to provide state and local policymakers with accurate information about existing options for treating of methamphetamine addiction and the success of these modalities. The strategy acknowledges that there is a "common misperception that methamphetamine addiction is so addictive that it is impossible to treat" (p. 26). However, there is no discussion of what the relevant Administration agencies intend to do toward correcting this "common misperception." Based on NAMSDDL's work with states, I can tell you that a number of the individuals who have this "common misperception" are state legislators and other decision makers who are charged with making funding, policy and programmatic decisions. While ongoing research related to needed improvements in addiction treatment is always beneficial, it is also important to provide current decision makers with accurate information about addiction treatment and its effectiveness upon which they can base resource allocation and other policy decisions.

States Need for Relevant Data, Meth-Related Information from a Central Resource

In working with states during the past two years on meth-related legislation, NAMSDDL staff has heard repeatedly that our organization's services were valued

because NAMSDDL provides a central source of what other states have done legislatively and information – anecdotal and quantitative as provided by states – re: shortcomings and successes of a variety of legislative efforts. These state officials have frequently expressed the frustration of the lack of national data related to methamphetamine, particularly the costs to states of meth and its related issues which would have been invaluable in their efforts to make need-based arguments to their legislatures. In several cases, states – in the words of one state official – quickly “meat-cleaved” together their best estimates based on figures available to them in order to get an idea of resources lost to this drug and its production as well as resources to be saved by addressing these issues legislatively. States have expressed the need for mechanisms designed to 1) efficiently coordinate available information on meth issues from the agencies, their grantees and state colleagues, 2) organize the data and materials in a cogent manner, 3) identify policy implications of the materials/information and 4) disseminate the information to state legislators and other policymakers in a timely, responsive way so they can use the data/information to make informed decisions. The strategy does not propose to remedy this need for comprehensive, coordinated data at the national level

With regard to data related to meth laboratories, the strategy necessarily addresses the current shortcomings of the El Paso Intelligence Center, Clandestine Laboratory Seizure System (EPIC’s CLSS). To this point, it has not been unusual for NAMSDDL staff to receive calls from state officials or Congressional staff – new to working on meth-related issues – asking why there is a significant gap between states’ reporting numbers of meth laboratories and EPIC’s stats, with the former being a much higher figure. Therefore, the collection process of EPIC does need to be addressed to insure a more accurate assessment of nationwide success in reducing domestic meth labs. However, the strategy places the onus on the states – specifically state and local law enforcement – at a time when their resources are stretched and, per the Administration’s proposed “drug budget”, their future funding for addressing meth and other drug issues is in jeopardy.

Regional Methamphetamine Legislative and Policy Planning Conferences

Given the unprecedented level of states’ legislative efforts to address meth, states have expressed the need for regional planning to prioritize next steps for states and to coordinate initiatives within multistate areas. Therefore, as the strategy briefly mentions, NAMSDDL has agreed to partner with ONDCP, OJP/BJA, and the Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct four regional planning events to assist states with their state and regional legislative and policy efforts to address meth and its related issues. Each regional is intended to result in 1) a legislative and policy action plan for each state, 2) identification of laws and policies that are working or having positive benefits for a state that might be worthy of replication in other states in the region, 3) identification of issues, concerns, problems that exist in multiple states, including those that require interstate resolutions, 4) identification of states’ needs for federal assistance and federal requests for states’ assistance, and 5) identification of issues, concerns, and initiatives that may require collaboration among federal, state and local officials to resolve. In order to accomplish these objectives, NAMSDDL will convene regional events that 1) engage a multidisciplinary team of select individuals

from each state and the District of Columbia (D. C.), 2) plenary sessions to inform discussion and planning, and 3) focus on facilitated group processes designed to produce prioritized actions plans. A complete overview of this project has been submitted with my testimony for the record. By having NAMSDDL partner to convene these events, these federal agencies appear to recognize that the coordination of priorities and strategies on these issues can improve efficient allocation of resources to accomplish goals and objectives.

The first regional meth legislative and policy planning conference will be held for the South-Southeastern states, July 13-14, 2006 in Birmingham, AL.

State Prescription Drug Monitoring Programs

In the *Synthetic Drug Control Strategy*, I am encouraged to see the Department of Justice (DOJ), Health and Human Services (HHS), and ONDCP continuing to emphasize addressing the diversion of, misuse of, abuse of and addiction to prescription drugs. The strategy also reflects an acknowledgement and awareness of the need to balance reducing the nonmedical use of prescription drugs with safeguarding the access to controlled substance prescription drugs for licit, medical purposes. Further, it is helpful that these Administration agencies continue to recognize that state prescription drug monitoring programs (PDMPs) can be valuable tools for states in addressing prescription drug diversion, misuse, abuse, and addiction.

As the strategy indicates, a growing number of states are establishing PDMPs and passing enabling legislation to do so. To date, twenty-three states are operating PDMPs and eight states have enacted legislation authorizing them to be established. In NAMSDDL's work with states on PDMPs, many have appreciated and benefited from the Administration's emphasis on addressing nonmedical use of prescription drugs and support of state prescription drug monitoring programs. However, the strategy presents the ambitious goal of all 50 states establishing PDMPs before the end of 2008. Given that most states take a minimum of two legislative sessions to pass enabling legislation for these programs, several states have entrenched opposition, and a number of states' legislatures meet every other year, I must caution the subcommittee – as I have my federal colleagues – that this goal may not be realistic.

The strategy emphasizes an important point re: the need to collect data from the administrators of existing PDMPs about the scope of prescription drug problems in their states and the benefits of the PDMP in addressing these issues. As additional states work to assess the need for PDMPs, this outcome data is critical to stakeholders in establishing new state PDMPs.

On a related point, the strategy speaks of sharing “best practices” with states that already have PDMPs and of working with these states to obtain better data about the extent and nature of prescription drug abuse. This information will certainly help those states improve the operation of their existing PDMPs. However, states beginning to consider a PDMP as a viable option for addressing prescription drug addiction, abuse and

diversion also need the collected data and operational information. This would enable states in the PDMP planning stages to avoid “re-inventing the wheel,” to take advantage of lessons learned from their state colleagues, and to very likely save resources toward establishing programs. Further, state PDMP administrators have re-asserted that collaborating with officials in neighboring states to establish PDMPs is one of their top priorities. Their overall goal is to ensure all states in their respective regions have these monitoring programs. Therefore, states stand ready and willing to partner in this effort, as they have for many years.

The strategy acknowledges that doctor shopping is “typically for the purpose of feeding an addiction” (p. 33), and that health care providers may use the PDMP information as a tool for early identification. For a state PDMP to be effectively used as such an early identification tool, health professionals need to understand where to turn for assessment and treatment assistance. Therefore, I hoped the strategy would include an emphasis on assisting state PDMPs and the health professionals (who may be authorized to access state PDMP data) to connect with addiction treatment resources, particularly through the education of physicians and other health professionals about the availability of options for assessment and referral to addiction treatment in their states.

I would also have liked the strategy to commit to assisting states to develop efficient, coordinated technical and legal procedures for sharing information among states PDMPs to address interstate diversion and nonmedical use. Interstate sharing of this kind is a priority among current state PDMP officials and point of concern among members of Congress working to address these issues.

Additional Federal Assistance Needed by States to Address Nonmedical Use of Prescription Drugs

The Internet remains a concern for states in addressing prescription drug diversion, misuse, abuse, and addiction. Therefore, I am encouraged that this will remain an Administration priority per the strategy. Points of access about which states are concerned that are unaddressed in the strategy are military hospitals, Veterans Administration hospitals, and tribal lands. Pharmacies in or on these entities may not be bound by state law and thus may not be required to report to state PDMPs. However, officials from states in which these entities have a significant presence believe that these dispensaries present opportunities for diversion, abuse, and misuse and it would benefit states to have them report to these programs. States continue to ask for federal assistance to address this gap.

Another need is for proactive educational initiatives, developed in conjunction with state PDMP officials, to provide useful PDMP information to decision makers in states who are beginning to address the problem of prescription drug addiction, abuse and diversion. This information would include, but not be limited to: the benefits of PDMPs, information to health professionals and law enforcement in undertaking their professional responsibilities within the PDMP, and potential cost savings to a state of a PDMP.

Input from, Coordination with the States to Address Synthetic Drugs

I was encouraged by the strategy's acknowledgement of states' initiative, leadership, and success in address synthetic drug issues. However, the strategy does not include a description of how states' input will be solicited and incorporated through an ongoing mechanism to ensure that the gap between federal action and states' needs does not continue or redevelop. Instead, the document takes the "top down" approach of the federal agencies administering to states, which is disappointing given the high level of state action and expertise in this arena.

The Administration agencies involved in this strategy tout and encourage state drug control strategies. The document contends that some states have drug control strategies while most do not. If the agencies believe this to be the case, what initiatives will they undertake moving forward which differ from those taken in past years to better influence states to develop coordinated strategies? How will they determine which states do not have these plans? These types of intended action steps are not outlined in the strategy toward the stated goal of increasing the number of states with drug control strategies.

Concluding Remarks

Congressman Souder and Ranking Member Cummings, I want to add that in NAMSDL's ongoing work with states, our contacts consistently recognize the leadership that Congress has shown in addressing methamphetamine and in retaining much needed federal dollars for state and local efforts to address alcohol and other drug issues. Specifically, they often reference this subcommittee and its attention to these critical issues. I extend their thanks and praise to you and your colleagues.

I also want to commend our national partners on this panel (*listing current as this testimony goes to print*): National Narcotic Officers' Associations' Coalition (NNOAC), Community Anti-Drug Coalitions of America (CADCA), National Association of State Alcohol/Drug Abuse Directors (NASADAD), and the National Association of Counties (NACo). Their constituents and members are many of the leaders at the state and local levels that I reference in my testimony. I am grateful for their collective work.

Thank you once again for the opportunity to share this information with you. I would be happy to answer any questions that you have as the hearing proceeds.

**STATES' LEGISLATIVE EFFORTS TO ASSIST CHILDREN FOUND IN OR NEAR
METHAMPHETAMINE LABORATORIES¹**

The National Alliance for Model State Drug Laws' (NAMSDL) ongoing review of specific state legislative language intended to assist children found in or near methamphetamine laboratories indicates that states are adopting three general categories of statutory provisions:

FIRST CATEGORY:

Increases penalties for performing certain prohibited activities on the same premises where a child is located or in the presence of a child or other member of a protected class

- 1) Prohibited activities include:
 - Manufacturing methamphetamine or controlled substances,
 - Attempting to manufacture methamphetamine or controlled substances,
 - Storing chemicals or waste, by-products of methamphetamine production,
 - Possessing chemicals, methamphetamine or controlled substances,
 - Causing or permitting a child to be exposed to, inhale, ingest, or otherwise come in contact with methamphetamine, chemicals or controlled substances.
- 2) Member of the protected class sometimes includes the elderly and/or vulnerable/dependent adults (e.g. adults with mental or physical disabilities).
- 3) Age of the "child" who is protected can vary among states, but the recent trend is to include those less than 18 years of age in the protected class.
- 4) States are increasing the number of locations where the conduct of prohibited activities in the presence of or on the same premises as a child subjects the offender to increased penalties. The expansion of the locations is often accomplished through broadening the definition of "premises" or "in the presence of". The locations where increased penalties are applicable can include:
 - In the physical presence of the child.
 - The residence of a child
 - A location where a child can reasonably be expected to be (e.g. park, playground)
 - A hotel room or other room offered for overnight accommodation
 - Multi-unit residential dwelling, apartment unit, rented room
 - Building
 - Structure
 - Dwelling house
 - Conveyance
 - Motor vehicle or vessel

¹ This update does not contain legislation addressing the child endangerment issue as it pertains to: (a) pregnant and addicted mothers/prenatal exposure to alcohol and/or controlled substances, (b) manufacturing controlled substances in or near "drugfree zones" such as places of worship, playgrounds, schools, day care facilities, etc., (c) driving under the influence of alcohol or controlled substances with a child present in a vehicle, (d) failing to place a child in a child safety seat/failing to employ the use of a seat belt or (e) providing alcohol or tobacco products to minors. Although the National Alliance for Model State Drug Laws (NAMSDL) recognizes that such acts endanger children, we consider the aforementioned offenses as separate research issues out of the customary purview of child endangerment laws enacted to address the urgency fueled by the existence of clandestine laboratories, especially those used to manufacture methamphetamine.

- Propelled vehicle or structure adopted for overnight accommodations of persons or for carrying on business
 - Offices
- 5) The penalties are graduated depending on the severity of the injury or the death of the child or other protected class member

SECOND CATEGORY:

Increases penalties for performing certain prohibited activities on the same premises where a child is located or in the presence of a child or other member of a protected class

AND

Defines prohibited activity as child endangerment, neglect, or abuse

The intent is to facilitate the child's access to services which state and local authorities traditionally provide to children identified as endangered, neglected or abused.

THIRD CATEGORY:

Emergency or exigent circumstances

These provisions allow a first responder, generally a law enforcement officer, to immediately take a child from a methamphetamine laboratory location to child protective services or other appropriate officials without first obtaining a court order.

**STATES' LEGISLATIVE/REGULATORY MEASURES TO ADDRESS
CLEAN-UP AND REMEDIATION OF FORMER METHAMPHETAMINE LAB SITES**

The National Alliance for Model State Drug Laws' (NAMSDL) ongoing review of state laws, regulations and guidelines, and proposed or pending bills, regulations and guidelines indicates that states focus on establishing guidance in four key areas:

1. Decontamination Standards

- Thirteen (13) states have set decontamination standards for methamphetamine (meth): Alaska, Arizona, Arkansas, California, Colorado, Idaho, Minnesota, Montana, North Carolina, Oregon, Tennessee, Utah and Washington

Of these states, four (4) set standards for lead and mercury: California, Oregon, Tennessee, and Washington

Current standards are feasibility-based standards which reflect the level of "clean" which states believe, based on available research and science, will provide citizens some protections from long-term adverse health consequences of exposure to meth lab environments.

Optimal standards would be health-based standards which establish the level to which one would need to clean to prevent the average person from suffering long-term adverse health consequences. Existing research is insufficient for federal, state and local officials to determine that level of "clean". In the absence of such definitive research, states have implemented feasibility-based standards.

2. Regulation of clean-up contractors:

- Establishing certification and training requirements for contractors and their employees
- Establishing work plans

3. Requiring Certain Types of Notice, including:

- Notice upon discovery of a meth lab to specified state and local officials, and property owners
- Notice by the seller to a buyer or other transferor that a particular property was a former meth lab site (Arizona, Alaska, California, Minnesota, Oregon)
- Public notice through a Web site or a state-certified/authorized list or registry of locations that have been former meth lab sites and/or of clean-up contractors certified or otherwise approved by the state.
- Notice in property records (e.g., filed with county auditors or a registrar of deeds) that a location has been the site of a meth lab, and, if applicable, that the property has been cleaned up and remediated.

4. Identifying Funding Options for Clean-up and Remediation of Former Meth Lab Sites

- Appropriations
- Offender assessments or penalties
- Federal grants or other federal monies

RESTRICTIONS ON OVER-THE-COUNTER SALES/PURCHASES OF PRODUCTS CONTAINING PSEUDOEPHEDRINE

STATE LEGISLATIVE/REGULATORY RESTRICTIONS

The National Alliance for Model State Drug Laws's (NAMSDL) review of 2005 state bills and/or regulations establishing or enhancing existing restrictions on over-the-counter sales/purchases of pseudoephedrine products. For comparative purposes, applicable provisions of existing laws which were enhanced in 2005 are included.

Also included is a review of 2006 state bills enacted by June 10, 2006.

MAJORITY OF STATES TAKE ACTION

42 states in 2005 and to date in 2006 passed measures establishing or enhancing restrictions on over-the-counter sales of pseudoephedrine products.

- 35 states passed bills in 2005
- 1 state – Virginia- issued an Executive Order requiring the state Department of Health (DH) to establish restrictions; The DH issued an emergency order effective until July 1, 2006. Virginia 2006 bill will take effective on July 1, 2006 as the emergency order ceases to be effective.
- Alaska, Idaho, New Mexico, Ohio, South Carolina and Vermont enacted bills implementing new restrictions; Colorado, Hawaii, Illinois, South Dakota and Wisconsin passed amendments to their 2005 laws.

COMMON THEMES

Restrictions on the Over-the-Counter Sales/Transfers or Purchases of Pseudoephedrine Products

Four (4) general categories of restrictions on the over-the-counter sales/purchases of pseudoephedrine products are found:

1. Restrictions on the display or offer of the products for sale.
2. Restrictions on who can sell/transfer and/or who can purchase the products, and the requirement to maintain a log/record of the transaction.
3. Restrictions on the quantity of a product that can be sold/transferred or purchased within a specified time frame.
4. Restrictions on packaging of the products.

Restrictions on the Display or Offer of the Products for Sale/Transfer

1. Scheduling of pseudoephedrine as a controlled substance 11 states

Schedule V – Arkansas, Illinois, Iowa, Kansas, Minnesota, Missouri, New Mexico, Oklahoma, West Virginia (sole-active pseudoephedrine), Wisconsin

Schedule III – Oregon; requires a prescription for all pseudoephedrine products

2. Placement of pseudoephedrine products in specified locations.

State legislative language often lists the methods below as options, requiring only that one option be used. However, in certain circumstances multiple placement methods must be used conjunctively.

- a. Behind a counter or in an area inaccessible to the public without assistance of an employee.
- b. In a locked display case or other locked location.
- c. Within the direct line of sight of a staffed counter.
- d. Within specified feet of a counter.

10 feet – Missouri

20 feet – Michigan

25 feet – Tennessee

30 feet – Indiana (convenience packages), Louisiana, Maine (applies only to 60 mg. single dose packages), Mississippi (multi-active), Texas, Virginia (multi-active), Wyoming

- e. In an area subject to constant video monitoring/surveillance
- f. Use of anti-theft mechanism or alarm system.
- g. Use of restricted shelving which allows a pseudoephedrine product to be released only every 15 seconds.

- h. Display of a limited number of packages of a brand or type in a public area.

No more than 1 package of any brand or type in a public area – North Dakota

No more than 3 packages or 9 grams of each stocked product can be placed on shelf – Louisiana

Restrictions on Who can Sell/Transfer and/or Who can Purchase the Pseudoephedrine Products and Log/Record Requirements

1. Seller/Transferor requirements.
 - a. Products must be sold by pharmacy/pharmacist/pharmacy technician or clerk: 14 states

Arkansas, Iowa (except 360 mg. or less of liquid products), Illinois (except convenience packages containing 360 mg. or less of liquid products), Kansas, Kentucky, Maine (except 60 mg. single dose packages offered for sale pursuant to specified display methods), Minnesota, Missouri, New Mexico, Oklahoma, Oregon, Tennessee, West Virginia, Wisconsin
 - b. Certified/authorized retail establishment in addition to pharmacy:

Alabama, California, Montana, Texas, Washington, Wyoming
2. Purchaser requirements.
 - a. Person must be a minimum age: 19 states

18 years of age – Alabama (sole-active), Arkansas, California, Colorado, Delaware, Indiana (inapplicable to convenience packages), Illinois, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Carolina, North Dakota, Ohio (purchase allowed in selected circumstances) Washington, West Virginia

16 years of age – Alaska, Texas
 - b. Person must produce a photo identification, generally government or school-issued: 33 states

Alabama (sole-active pseudoephedrine; in lieu of photo id can provide two other specified types of identification), Alaska (incorporates by reference identification requirement in Combat Meth Epidemic Act of 2005), Arkansas, California, Delaware, Hawaii, Idaho, Illinois (alternative options provided in select circumstances if purchaser is without a photo identification), Indiana (inapplicable to convenience packages), Iowa (applies to liquid products of 360 mg. or less of pseudoephedrine), Kansas, Kentucky, Louisiana (applies only if video surveillance is not used), Michigan Minnesota, Mississippi, Missouri (if purchaser not known to pharmacist or technician), Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio (sole-active pseudoephedrine), Oklahoma, Oregon, South Carolina (inapplicable to single sale packages of 60 mg. or less of pseudoephedrine) South Dakota, Texas, Tennessee, Virginia, Washington, West Virginia, Wisconsin.

In Maine, the requirement to produce identification to purchase pseudoephedrine products is implemented at the discretion of the pharmacist. The requirement even when implemented is inapplicable to 60 mg. single dose packages offered for sale pursuant to specified display methods.

- c. Person must sign a log or record of the individual sales transaction which is kept by the seller/transferor: 22 states

Alabama (sole-active pseudoephedrine), Alaska (incorporates by reference Combat Meth Act logbook requirement and exception re: single sale packages of 60 mg. or less of pseudoephedrine), Arkansas, Delaware, Hawaii, Illinois, Iowa (applies to liquid products of 360 mg or less of pseudoephedrine), Kansas, Kentucky, Louisiana (applies only if video monitoring not used), Minnesota, Montana, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina (inapplicable to single sale packages of 60 mg. or less of pseudoephedrine), Tennessee (only written log), Texas, Virginia, West Virginia, Wisconsin

Five additional states have a log or record requirement but do not require the purchaser to sign the log or record:

Maine (keeping of a log/record is voluntary), Michigan (log/record requirement applies only if products are not stored behind a counter or in a locked case), Oregon, South Dakota (record of identification of purchaser), Tennessee

Indiana requires completion of a log in a format approved by the state

police; this may require a signature. The log requirement is inapplicable to convenience packages.

3. Contents of log/record

Information often required:

- a. Name of purchaser.
- b. Date of transaction.
- c. Quantity/Amount and/or name of product.

Information sometimes required:

- a. Address of purchaser.
- b. Record of purchaser identification, such as driver's license number or date of birth.
- c. Seller's/Transferor's initials, name, signature or identification code.

Restrictions on the Quantity of a Product that can be Sold/Transferred or Purchased within a Specified Time Frame

1. Maximum amount of pseudoephedrine product that can be sold/transferred or purchased within 30 days.

9 grams:

Alaska (incorporates by reference requirement in Combat Meth Act),
Arkansas, Delaware, Hawaii, Idaho, Kentucky, Louisiana, Mississippi,
Missouri, Montana, New Mexico, North Carolina, Ohio, Oklahoma,
Oregon, South Dakota, Tennessee, West Virginia

7.5 grams:

Illinois, Iowa, Wisconsin

6 grams:

Minnesota, Alabama (The AL law makes it unlawful to purchase more than 6 grams within 30 days with the intent to manufacture)

methamphetamine. This is a variation on the traditional quantity requirement.)

2. Other time frames used to cap the amount of a pseudoephedrine product that can be sold/purchased:

a. In a single transaction.

This limitation is traditionally phrased as a maximum number of packages/grams of the product that can be sold/purchased in a single sale or transaction. For example:

Arkansas – No more than 3 packages or 1 package containing 3 grams or 96 units.

Hawaii, Pennsylvania, South Carolina – No more than 3 packages or 9 grams.

Idaho – No more than 9 grams.

Illinois – No more than 2 targeted packages.

Michigan – No more than 2 packages or 48 tablets or 2 convenience packages.

Missouri – No more than 2 packages or 6 grams of sole active pseudoephedrine; 3 packages or 9 grams of pseudoephedrine as a multi-active ingredient.

North Carolina – No more than 2 packages or 6 grams.

This limitation is sometimes combined with the 30 day quantity limitation. The legislative language sometimes caps the amount or number of packages/grams a seller can sell in a single transaction, and caps the number of grams that a purchaser can acquire within 30 days.

b. In a 24 hour period/Daily.

Illinois – No more than one convenience package containing no more than 360 mg. of liquid pseudoephedrine.

Iowa – No more than one package containing no more than 360 mg. of a liquid pseudoephedrine product

Nebraska – No more than 1,440 mg. of pseudoephedrine.

Alaska (incorporates by reference requirement in Combat Meth Act), Colorado, Hawaii, Vermont, Virginia – No more than 3.6 grams of pseudoephedrine.

Washington – No more than one transaction per 24 hours; no more than 2 packages or a single package containing 3 grams in a single transaction.

c. In 7 days or a week.

Indiana – No more than 3 grams (except convenience packages).

Kansas – No more than 3 packages.

Restrictions on Packaging of the Products

1. Maximum amount of pseudoephedrine that can be in one package/product.
 - a. 3 grams – most common
 - b. 2 grams – North Dakota
 - c. 1,440 mg. – Nebraska
 - d. 360 mg. – Iowa and Illinois, liquid pseudoephedrine product sold by retailers
 - e. 120 mg. – Indiana convenience packages
 - f. 60 mg. – Maine, single dose packages sold by retailers and offered for sale using specified display methods

2. Pseudoephedrine products must be in blister packs: 11 states

Alabama (30 mg. or more of pseudoephedrine), Arkansas, Georgia (sole-active pseudoephedrine), Illinois, Maine, Minnesota, Nebraska, North Carolina (30 mg. or more of sole-active pseudoephedrine), North Dakota, South Carolina (sole-active pseudoephedrine), Wyoming

No more than 2 unit doses in each pack, and if blister packs are infeasible, the product must be in unit dose pouches or packages: All states listed above except Alabama, Georgia, North Carolina, South Carolina

Exemptions/Exceptions to Restrictions on the Over-the-Counter Sales/Transfers or Purchases of Pseudoephedrine Products

1. Products for which a person has a valid prescription.
2. Products purchased/possessed by or sold/transferred to persons in the lawful course of their business, e.g., pharmacist, physicians, common carriers.
3. Pediatric products administered to children under 12 years of age.

The legislative language sometimes requires the product to cap the amount of pseudoephedrine in a single dosage for the exemption to apply. For example:
 - a. No more than 15 mg. for a solid product
 - b. No more than 15 mg. per 5 milliliters for a liquid product
 - c. No more than 2 milliliters for a total package of 1 fluid ounce if the product is intended for children under 2 years of age
4. Products not found to be used in illegal manufacture or that present no significant risk of use in illegal manufacture
5. Products formulated to prevent the active ingredient from being converted for use in illegal manufacture. A state will generally grant this exemption only upon application of the manufacturer.
6. Products that are in liquid, liquid gel, or liquid capsule form.

Traditionally states exempted/excepted liquid products in general from over-the-counter sales restrictions. However, several states narrowed this exemption as reports surfaced that liquid products were being used in the illegal manufacture of methamphetamine. For example, states:

- a. Applied the exemption to liquid products in which pseudoephedrine is not the sole active ingredient (e.g., Oklahoma)

- b. Allowed only liquid products in small or low dosage amounts to be sold by retailers (e.g., Iowa, Illinois)
- c. Maximized the amount of liquid products that can be sold in a single transaction (e.g., Arkansas, Missouri)

Some states exempted liquid products but specifically authorized a state agency to regulate the products if the agency determined that the products were being used in the illegal manufacture of methamphetamine.

Preemption

States often preempted localities or municipalities from imposing over-the-counter sales/purchase restrictions which were more restrictive than those required under state law:

Alabama, Arizona, California, Florida, Georgia (effective 1/1/06), Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Missouri, North Carolina, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas

NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS
REGIONAL METHAMPHETAMINE LEGISLATIVE AND POLICY PLANNING
EVENTS
COLLABORATIVE PROJECT WITH ONDCP, SAMHSA, and OJP/BJA

OVERVIEW

Overview of Project

The National Alliance for Model State Drug Laws (NAMSDL) has agreed to partner with the Office of National Drug Control Policy (ONDCP), Office of Justice Programs/Bureau of Justice Assistance (OJP/BJA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct four (4) regional planning events to assist states with their state and regional legislative and policy efforts to address methamphetamine (meth) and its related issues. Given the unprecedented level of states' legislative efforts to address meth, regional planning is needed to prioritize next steps for states and to coordinate initiatives within multistate areas.

Objectives of the Regional Meth Legislative and Policy Planning Events

Each regional is intended to result in (1) a legislative and policy action plan for each state, (2) identification of laws and policies that are working or having positive benefits for a state that might be worthy of replication in other states in the region, (3) identification of issues, concerns, problems that exist in multiple states, including those that require interstate resolutions, (4) identification of states' needs for federal assistance and federal requests for states' assistance, and (5) identification of issues, concerns, and initiatives that may require collaboration among federal, state and local officials to resolve. In order to accomplish these objectives, NAMSDL will convene regional events that 1) engage a multidisciplinary team of select individuals from each state and the District of Columbia (D. C.), 2) plenary sessions to inform discussion and planning, and 3) focus on facilitated group processes designed to produce prioritized actions plans.

Format of the Regional Meth Legislative and Policy Planning Events

Each regional meth planning event will be two days featuring four plenary sessions, five to seven (number will depend on size of region) facilitated group processes designed to produce prioritized actions plans, and a closing session featuring the public reading of priorities and action plans developed during the event.

Plenary sessions will be used to provide information that all participants need to hear, including practical results of various state laws and policies, national statistics and priorities, and federal and national resources available to states. NAMSDL will work with its federal agency partners and key national organizations to identify plenary session speakers and/or panelists for each regional event.

The majority of participants' time will be spent in the facilitated working groups. Two to three state teams will participate in each working group; on the second day of each regional event, the Governors' designees will meet with federal officials for facilitated planning sessions to identify states' needs for federal assistance and federal requests for states' assistance, as well as issues, concerns, and initiatives that may require collaboration among federal, state and local officials to resolve.

Consultants from NAMSDL's national network will be used to facilitate the working groups. These individuals are familiar with the issue areas to be discussed, have strong group facilitation skills, and work or have worked at the state and local levels. Many of these consultants work with NAMSDL on a regular basis with the model

state drug laws submits that the organization conducts on our Congressional appropriations (see **Capacity of NAMSDDL to Deliver**).

Participants in the Regional Meth Legislative and Policy Planning Events

NAMSDDL will work with the states and D. C., its federal partners, and relevant national organizations to identify and select 21 stakeholders to comprise each state's multidisciplinary team to participate (the DC team will have 5 members). The composition of each state's team will be representatives of the following:

1. Governor's designee
2. State Administrative Agency (SAA) for criminal justice
3. State law enforcement official
4. Prosecutor/District Attorney
5. State's State Associations of Addiction Services affiliate
6. Single state authority for substance abuse
7. Recovery community
8. State prevention coordinator (or equivalent)
9. State prevention association
10. Stakeholder in Drug Endangered Children effort
11. Business community
12. Native American/Tribal Lands
13. Community coalition
14. Community coalition
15. Stakeholder in cleanup and remediation efforts (addressing former meth lab sites)
16. Association of counties
17. Association of cities/municipalities
18. Local law enforcement official
19. Attorney General or his/her rep
20. State Senator
21. State Representative (Legislator)

The DC team will include a mayor's designee, law enforcement representative, addiction treatment professional, prevention/education specialist, and a community member.

Given the organization's longstanding working relationships with states, NAMSDDL has the capacity to conduct and coordinate the outreach to state officials necessary to build these teams.

NAMSDDL will also work with the federal agency partners to identify a select group of federal to attend and participate in the regional meth planning events in order to accomplish the above-stated objectives re: state/federal dialogue, problem solving, and action planning.

Defining the Regions

The four regions for these events and the states comprising each are as follows:

South/Southeast:

1. Alabama
2. Arkansas
3. District of Columbia
4. Florida
5. Georgia

6. Kentucky
7. Louisiana
8. Maryland
9. Mississippi
10. North Carolina
11. South Carolina
12. Tennessee
13. Virginia

West and Southwest:

1. Alaska
2. Arizona
3. California
4. Colorado
5. Hawaii
6. Idaho
7. Montana
8. Nevada
9. New Mexico
10. Oklahoma
11. Oregon
12. Texas
13. Utah
14. Washington
15. Wyoming

Northeast and Mid-Atlantic:

1. Connecticut
2. Delaware
3. Maine
4. Massachusetts
5. New Hampshire
6. New Jersey
7. New York
8. Ohio
9. Pennsylvania
10. Rhode Island
11. Vermont
12. West Virginia

Midwest and Great Lakes:

1. Illinois
2. Indiana
3. Iowa
4. Kansas
5. Michigan
6. Minnesota
7. Missouri
8. Nebraska

9. North Dakota
10. South Dakota
11. Wisconsin

Anticipated Timeframes and Locations for Regional Meth Legislative and Policy Planning Events

Timing of the regional events will ultimately depend on when NAMSDDL can access the funding committed by the federal partners engaged in this effort. The anticipated timing of these events and the host locations are as followed:

1. South/Southeast: July 13-14, 2006 in Birmingham, AL
2. West and Southwest: October 5-6, 2006 in Salt Lake City, UT
3. Midwest and Great Lakes: (date and location TBD)
4. Northeast and Mid-Atlantic: (date and location TBD)

NAMSDDL will work with the federal partners to set final dates and locations, once funding is available to make commitments to facilities, based on feasibility and utility for states (e.g. in the South/Southeast has several states with legislative sessions ending in April; therefore, the proposed timing for this regional would allow these states to consider information about what they passed or couldn't pass into the action plans).

Capacity of NAMSDDL to Deliver

The National Alliance for Model State Drug Laws (NAMSDDL) is a resource for governors, state legislators, attorneys general, drug and alcohol professionals, community leaders, the recovering community, and others striving for comprehensive and effective state drug and alcohol laws, policies, and programs. A 501(c)(3) Congressionally funded non-profit, NAMSDDL is the successor of the President's Commission on Model State Drug Laws. In this capacity, NAMSDDL has conducted 24 state summits that served as needs assessment and action planning mechanisms for states in addressing alcohol and other drug issues. These strategic events bring together a wide range of state stakeholders including elected officials, addiction treatment professionals, law enforcement officials, prevention specialists, state agency officials, prosecutors, youth, educators, school administrators, the business community, community coalitions, the recovery community, and others working to maintain, enhance, and expand efforts to address alcohol and other drug problems. Over 100 recommendations and related actions plans are crafted during the facilitated discussions that comprise these summits. A number of states continue to use these recommendations and action plans as "blue prints" for their alcohol and other drug efforts.

Specific to methamphetamine, NAMSDDL has emerged as the primary national resource for states on legislative and policy efforts to address meth and its related issues. Due to the high volume of requests for technical assistance from states, NAMSDDL has held two national conferences on legislative and policy options related to meth. Additionally, NAMSDDL has produced a variety of legislative analysis and bill tracking documents to assist states, Congressional staff, and federal officials in understanding states' legislative efforts to address precursor chemicals, drug endangered children, cleanup and remediation of former meth lab sites, and other corollary issues; these documents are posted on NAMSDDL's Web site at www.natalliance.org/publications.

Given both NAMSDDL's strong and longstanding track record in working with states on strategic planning related to alcohol and other drug efforts and its nationally recognized work on meth-related legislation and policy, ONDCP, OJP/BJA, and SAMHSA support this organization in conducting these regional meth planning meetings to assist states.

Mr. SOUDER. Ms. Thau.

STATEMENT OF SUE THAU

Ms. THAU. Chairman Souder, Ranking Member Cummings, Congresswoman Watson, thank you for the opportunity to testify today on behalf of the Community Anti-Drug Coalitions of America and our more than 5,000 coalition members nationwide. I am pleased to provide you with CADCA's perspective on the Synthetic Drug Control Strategy.

During my tenure as an OMB Budget Examiner, I analyzed many proposed national strategies. I know firsthand that the ones with the most impact had sufficient budgetary and other resources allocated to them to ensure they achieved results. The Synthetic Drug Control Strategy seems comprehensive. However, it simply repackages the administration's existing budget priorities. The Strategy ignores key programs that provide the majority of the community infrastructure and core support to local law enforcement prevention and treatment efforts to deal with meth where it has emerged as a crisis.

Prevention is the first line of defense in protecting communities from drug abuse, and it is not a one-size-fits-all proposition. It hinges on the extent to which schools, parents, law enforcement, business and the faith community work comprehensively to implement a full array of education, prevention, enforcement and treatment initiatives.

Unfortunately, the prevention portion of the strategy is very weak and only highlights three programs. It totally ignores two of the main Federal programs that have been addressing meth, the Drug Free Communities program and the State grants portion of the Safe and Drug Free Schools program. These programs are vitally important because they fund community and school-based prevention infrastructures that can immediately incorporate meth components where meth is a problem.

We know people do not usually start their drug-using careers with meth, because, as we mentioned before, the mean age at which people initiate meth use is 22. The epidemiology of drug use indicates that use trends often spread to adolescents. So although meth is not currently a major issue among most school-aged youth, it certainly could become one. In fact, in many communities where meth is a crisis, use rates for school-aged youth are way above State and national averages.

The prevention lesson to be learned from meth use, given its relatively late onset, is that the more successful we are at general drug prevention, the less we will have to deal with meth use and addiction.

CADCA knows from its members that this is already happening. Coalitions know what their local drug problems are and take the necessary steps across community sectors to counteract them. The strategy itself points out that States and cities must be organized to recognize and deal with meth, yet it totally fails to mention the Drug Free Communities program which has been very successful in addressing meth issues. Communities with existing anti-drug coalitions can identify and combat meth problems quickly and before they attain crisis proportion.

Coalitions throughout the country have effectively responded to the meth crises and have seen reductions in its use. For example, the Salida Build a Generation coalition in Salida, CO, used local school survey data to ascertain that meth was a problem in their community. When compared to Monitoring the Future data for the same time period, their community's rate of lifetime meth use for 10th graders was 61.9 percent above the national rate. As a result of implementing a multi-sector approach, the Salida coalition has contributed to a 59 percent reduction in meth use among 10th graders, from 13.9 percent in 2004 to 5.7 percent in 2006.

School-based prevention should also be a vital component of any comprehensive strategy to deal with meth. Where meth is identified as an issue, schools have incorporated meth education into their existing evidence-based programs. The Safe and Drug Free Schools and Communities program has contributed to significant reductions in meth use among school-aged youth in many States hit by the meth epidemic.

For example, in Idaho, the Safe and Drug Free School program contributed to a decrease of 51.9 percent in lifetime meth use among 12th graders, from 10.4 percent in 1996 to 5 percent in 2004.

In addition, the 20 percent Governor's setaside for this program has been used to address meth. For example, Washington State has used their setaside to develop meth action teams in every county in the State.

Communities and schools must have effective prevention infrastructures in place to be able to address meth and prescription drug abuse. Media campaigns and student drug testing are beneficial but not sufficient to provide the stable and effective community wide prevention systems required to implement data-driven programs and strategies to deal with all of the community's drug issues, including meth.

As my testimony has shown, communities with these capabilities have actually beaten back their meth problems among school-age youth before they reach crisis proportions.

Thank you for the opportunity to testify. I would be happy to answer any questions you may have.

Mr. SOUDER. Thank you.

[The prepared statement of Ms. Thau follows:]

“Evaluating the Synthetic Drug Control Policy”
Government Reform Committee
Criminal Justice, Drug Policy and Human Resources Subcommittee
Written Testimony of Sue R. Thau
Public Policy Consultant
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Chairman Souder, Ranking Member Cummings and other distinguished members of the Criminal Justice, Drug Policy and Human Resources Subcommittee, thank you for the opportunity to testify before you today on behalf of Community Anti-Drug Coalitions of America (CADCA) and our more than 5,000 coalition members nationwide. I am very excited to provide you with CADCA’s perspective on the 2006 Synthetic Drug Control Strategy.

During my tenure as an OMB Budget Examiner, I had the opportunity to analyze many proposed national strategies on a variety of topics. I know first hand that the ones that had the most impact not only laid out a vision, and measurable goals and objectives, but also had budgetary and other resources allocated to them to ensure they achieved results. The Synthetic Drug Control Strategy (the Strategy) outlines a number of important goals and tools for combating methamphetamine and prescription drug abuse over the next three years. On the surface, it seems comprehensive and inclusive of both supply and demand reduction programs and initiatives. However, upon closer scrutiny the Strategy essentially repackages the Administration’s existing budget priorities for enforcement, treatment, and prevention. It totally ignores the key programs that provide the majority of local infrastructure currently operating to address both the supply of, and demand for, methamphetamine in communities where it has emerged as a crisis. The Strategy does not mention the Byrne/JAG program, the State Grants portion of the Safe and Drug Free Schools and Communities (SDFSC) program, the Drug Free Communities (DFC) program, or the Substance Abuse Prevention and Treatment Block Grant. Together these four programs provide core support to communities for local law enforcement, prevention, and treatment efforts to deal with all drug issues, including methamphetamine.

Having worked with CADCA for over 10 years, I have come to appreciate the importance of our nation’s drug prevention efforts as the first line of defense in protecting communities from the ravages of drug abuse. CADCA knows that effective prevention is not a “one size fits all” proposition. Successful prevention hinges on the extent to which schools, parents, law enforcement, business, the faith community, and other community groups work comprehensively and collaboratively through community-wide efforts to implement a full array of education, prevention, enforcement and treatment initiatives.

The prevention component of the Strategy starts by referencing NIDA’s *Preventing drug use among children and adolescents: A research-based guide*, which is an excellent tool for implementing effective school and community-based approaches. Unfortunately, the remainder of the prevention portion of the Strategy is weak and only highlights three drug prevention programs: the National Youth Anti-Drug Media Campaign (the Media Campaign), the Student

Drug Testing Initiative and the Strategic Prevention Framework State Incentive Grant (SPF SIG) program. CADCA fully supports these three programs as important components of a comprehensive national drug prevention strategy. The issue is that by themselves, these programs do not constitute the necessary community-based infrastructure actually needed to tackle local drug issues, including methamphetamine.

While CADCA is supportive of the Media Campaign and applauds the fact that it has just launched a series of methamphetamine ads, this program, if not reinforced by other comprehensive school and community-based prevention efforts, will not be sufficient to prevent methamphetamine use by itself. Likewise, student drug testing, if not built on a solid foundation of comprehensive prevention/intervention programming, is not capable of effectively preventing methamphetamine use by itself.

The one comprehensive program mentioned in the Strategy is the SPF SIG program. The SPF SIG is a discretionary grant program to states, territories and tribes that relies on comprehensive, community-wide prevention infrastructures, such as anti-drug coalitions, to plan and implement the strategies and programs to meet the actual epidemiological needs of communities. Twenty-four states and two territories currently have SPF SIG grants. SAMHSA anticipates that an additional 12-15 grants will be awarded in FY 2006. Unfortunately, the President's FY 2007 budget request recommends reducing this program by approximately \$11 million.

The Strategy totally ignores two of the main federal programs that have been addressing methamphetamine: the DFC program and the State Grants portion of the SDFSC program. These programs are vitally important because they fund community and school-based prevention infrastructures that can immediately incorporate methamphetamine components when this drug is identified as a problem.

We know that people don't usually start their drug abuse and addiction "careers" with methamphetamine. The mean age at which people initiate methamphetamine use is 22. This compares to mean ages of 15.6 for alcohol, 16 for inhalants, 16.2 for cigarettes, 18 for marijuana, and 20 for cocaine (see charts contained in **Attachments 1 and 2**).

The epidemiology of drug use indicates that, over time, use trends often "spread" to other vulnerable groups, and finally to adolescents. Given these facts, we cannot ignore that although methamphetamine is not currently a major issue among most school-aged youth, as measured by national surveys, it could certainly become one. In many communities where methamphetamine is a crisis, methamphetamine use rates for school-aged youth are way above state and national averages for 30 day and lifetime use. We should not center our prevention efforts around national averages and national trends, they must be flexible enough to address local problems before they become national trends.

The prevention lesson that needs to be learned from the epidemiology of methamphetamine use, given its relatively late onset, is that the more successful we are at general prevention of alcohol, tobacco, and marijuana use in younger adolescents, the less we will have to deal with methamphetamine use and addiction in 18 to 24 year olds. We can do this. We have data and outcomes to show that with effective, community-wide drug prevention, which includes

evidence-based school programming, communities are in fact markedly reducing their methamphetamine use rates among school-aged youth.

In conversations that CADCA has had with its member coalitions, it is clear that this is already happening. Coalitions know what drugs the youth of their communities are using, and are taking steps to counteract them. It is, therefore, shortsighted of the Strategy not to mention that methamphetamine prevention is currently being incorporated into existing statewide, school and community-based prevention efforts currently funded through the DFC and SDFSC programs and that these programs have made a difference.

Drug Free Communities Program

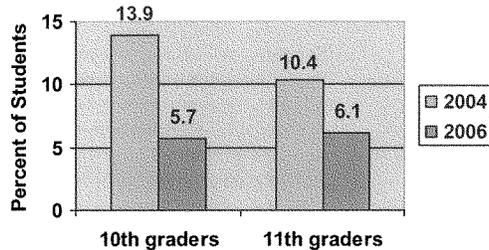
The Strategy itself points out that states and cities must be organized to recognize and deal with methamphetamine. Yet it fails to mention, even as a resource, the Drug Free Communities (DFC) program, which has been very successful in identifying and addressing methamphetamine issues in communities where it has emerged as an issue.

Coalitions should be an essential component in any comprehensive methamphetamine strategy because they are data driven, know their community epidemiology and are capable of understanding the multi-sector interventions required to reduce the availability and use of methamphetamine.

Communities with existing anti-drug coalitions can identify and combat methamphetamine problems quickly and before they attain crisis proportions. Methamphetamine is a multi-dimensional problem that demands comprehensive, coordinated solutions involving the collaboration of multiple community sectors that leverage community resources and major levels of citizen involvement. Coalitions throughout the country have effectively responded to the methamphetamine crisis and have seen tremendous reductions in its use. For example, the Salida Build a Generation ® coalition, in Salida, Colorado, has implemented multiple strategies to reduce substance use among youth, utilizing a multi-sector approach. Because the Salida Build a Generation ® coalition uses a data driven approach, it was able to ascertain early on that methamphetamine was an emerging problem in their community. In fact, their local school survey data indicated that when compared to Monitoring the Future (MTF) for the same time period, their community's rate of lifetime methamphetamine use for 10th grade students was 61.9% above MTF.

As a result of implementing a multi-sector approach to combat its methamphetamine issue among school aged youth, the Salida Build a Generation ® coalition has contributed to impressive reductions in methamphetamine use for 10th and 11th graders in the community. For example, the number of 10th grade students reporting lifetime use of methamphetamine decreased at a rate of 59.0%, from 13.9% in 2004 to 5.7% in 2006. Similarly, lifetime use by 11th grade students decreased at a rate of 42.3%, from 10.4% in 2004 to 6.1% in 2006.

Lifetime Methamphetamine Use



To achieve these results, the Salida Build a Generation® coalition implemented community education forums to involve and educate the community about the dangers of youth drug use, with an emphasis on methamphetamine. They also implemented a “Youth @ Crossroads” program, which works with first-time, non-violent youth offenders who are arrested on methamphetamine, alcohol and other drug-related charges. The “Youth @ Crossroads” program provides a combination of proven prevention education, community service and alternative activities to prevent future problem behavior. The coalition also has developed a social norming campaign, entitled “Now You Know” to educate the community about the perceived vs. actual norms around youth methamphetamine and other alcohol and drug use issues. Taken together, these strategies have led to substantial reductions in methamphetamine use.

Additional examples of how selected DFC grantees have successfully dealt with methamphetamine issues are contained in [Attachment 3](#).

The State Grants Portion of the Safe and Drug Free Schools and Communities Program

School-based prevention programs should be a vital component of any comprehensive strategy to deal with methamphetamine. Effective methamphetamine prevention must be built onto a solid foundation of evidence based drug and alcohol prevention strategies and programs.

The State Grants portion of the SDFSC program is the primary source of federal funding for school-based prevention that directly targets all of America’s youth in grades K-12 with drug education, prevention, and intervention programming. The program funds essential and effective services including: peer resistance and social skills training, parent education, student assistance, and education about emerging drug trends, such as methamphetamine. It also provides for targeted, coordinated school-community efforts to reduce methamphetamine use among community members. Schools have incorporated methamphetamine education into existing evidence-based programs when methamphetamine is identified through school surveys as an issue. This program has contributed to significant reductions in methamphetamine use among school-aged youth in many of the states that have been hardest hit by the methamphetamine epidemic. For example:

California – Between 1997 and 2002 the California SDFSC program contributed to a decrease of 52.9% in past 30 day methamphetamine use among 9th graders. In 1997, 3.4% of respondents reported using methamphetamine in the past 30 days, while in 2002 only 1.6% of respondents had used methamphetamine for the same time period (California Student Survey, 1997 & 2002).

Hawaii – Between 1998 and 2002 the Hawaii SDFSC program contributed to a decrease of 37.3% in lifetime methamphetamine use among 10th graders. In 1998, 6.7% of respondents reported using methamphetamine in their lifetime, while in 2002 only 4.2% of respondents had used methamphetamine in their lifetime (Hawaii Student Alcohol, Tobacco and Other Drug Use Study, 2002).

Idaho – Between 1996 and 2004 the Idaho SDFSC program contributed to a decrease of 51.9% in lifetime methamphetamine use among 12th graders. In 1996, 10.4% of respondents reported using methamphetamine in their lifetime, while in 2004 only 5.0% of respondents reported methamphetamine use in their lifetime (Idaho Survey, 1996 and SDFS Survey, 2004).

Massachusetts – Between 1999 and 2003 the Massachusetts SDFSC program contributed to a decrease of 44.1% in lifetime methamphetamine use among 11th graders. In 1999, 9.3% of respondents reported using methamphetamine in their lifetime, while in 2003 only 5.3% of respondents reported methamphetamine use in their lifetime (Youth Risk Behavior Survey Results for Massachusetts, 2003).

Additional examples of statewide outcomes for methamphetamine achieved by the State Grants portion of the SDFSC program are contained in **Attachment 4**.

In addition, the 20% Governor's set aside from the State Grants portion of the SDFSC program also has been used to address methamphetamine issues in many states. For example, Washington State has used money from the 20% set aside to develop Meth Action Teams in every county in the State. These teams all include law enforcement as well as the other key community sectors, such as: local government; schools; health departments; and community leaders. These Meth Action Teams focus on reducing methamphetamine use through comprehensive community wide strategies to address the supply of, and demand for, methamphetamine on a county-wide basis through enhanced enforcement, environmental strategies and community trainings to raise awareness about methamphetamine (see **Attachment 5**).

The Administration's proposal to eliminate the State Grants portion of the SDFSC program would decimate the nation's school-based substance abuse prevention infrastructure. Research has found that adolescents in small towns and rural areas are quite vulnerable to methamphetamine use, given the power of peer influences in rural environments and the historic appeal of stimulant drugs to rural youth.¹ Rural and frontier communities, where methamphetamine production and use inflict the greatest harm, would be left with virtually no school-based drug prevention programming if the Administration's proposal is carried out.

¹ Wermuth, Laurie. (2000). *Journal of drug education*. "Methamphetamine use: Hazards and social influences." 30(4). 423-433.

The SDFSC program is the cornerstone of school-based drug prevention and intervention activities. Without it there would be no staff in our nation's schools with the responsibility to provide general drug education and specialized programming for specific drugs such as methamphetamine. Congress needs to intervene again this year to ensure that this program is not only sustained, but funded at the highest possible level.

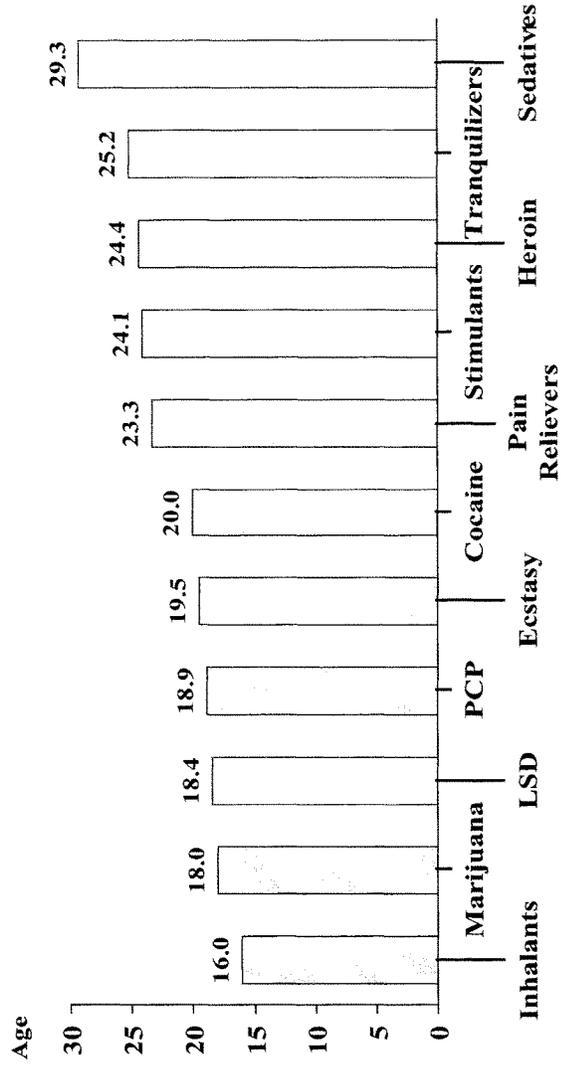
Conclusion

Methamphetamine is a tricky drug epidemic. While it does not appear from an epidemiological perspective to be a national drug crisis, it is definitely a major local and regional drug epidemic in many areas of the country. In that same vein, although methamphetamine looks like it is not a big drug issue among 8th, 10th, and 12th graders based on MTF, this national data set masks the fact that many communities are seeing methamphetamine statistics for these same grade levels, far in excess of what MTF is measuring in its national survey sample. For this reason, it is not valid to look only at national survey data as indicative of the methamphetamine crisis. It is crucial that states and communities collect and analyze local data to enable them to recognize and immediately respond to emerging methamphetamine use trends among adults and adolescents.

There will always be new and emerging drug trends. Communities and schools must have the effective prevention infrastructures in place to deal with all drug and alcohol issues, including new and emerging drugs, such as methamphetamine. Media campaigns and boutique programs, such as the Student Drug Testing Initiative, are beneficial but not sufficient to provide the organized, stable, and effective school and community-wide prevention systems required to implement evidence-based programs and data driven strategies to deal with community drug issues over time. As my testimony has shown, communities with these capabilities have actually beaten back their emerging methamphetamine problems before they have reached crisis proportions.

Attachment 1

Mean Age for Past Year Initiates, by Illicit Drug: 2004



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004

Attachment 2

Table 4.34B Mean Age at First Use among Past Year Initiates of Substance Use Aged 12 or Older, by Gender, 2003 and 2004

Substance	MEAN AGE					
	Total			Male		Female
	2003	2004	2003	2004	2003	2004
ILLICIT DRUG¹	19.7	20.1	17.7	18.5	21.2	21.2
Marijuana and Hashish	17.5	18.0	17.8	16.7	17.2	19.0
Cocaine	19.8	20.0	20.0	20.0	19.7	20.2
Crack	22.9	21.9	23.8	20.5	21.9	23.1
Heroin	20.9	24.4	21.5	22.7	19.8	26.4
Hallucinogens	17.9	18.7	18.6	18.7	17.2	18.7
LSD	17.2	18.4	17.9	18.2	16.2	18.6
PCP	17.4	18.9	17.4	17.7	17.4	20.3
Ecstasy	19.7	19.5	20.2	20.5	19.2	18.3
Inhalants	16.0	16.0	16.5	15.7	15.5	16.3
Nonmedical Use of Psychotherapeutics ²	23.9	24.7	19.8	24.1	26.4	25.1
Pain Relievers	24.0	23.3	20.0 ^a	22.9	26.8	23.8
OxyContin ³	--	24.5	--	25.2	--	23.6
Tranquilizers	22.9 ^b	25.2	21.1	23.1	24.0	26.5
Stimulants	22.1	24.1	19.3	27.2	23.8	21.7
Methamphetamine	20.4	22.1	19.9	20.8	20.8	23.1
Sedatives	31.1	29.3	19.1	21.6	37.3	33.1
ILLICIT DRUG OTHER THAN MARIJUANA¹	21.7	21.7	18.3 ^b	20.5	24.2	22.7
CIGARETTES	16.9	16.7	16.6	16.6	17.1	16.8
Daily Cigarette Use ³	19.8	18.8	18.1	19.0	21.2 ^a	18.6
SMOKELESS TOBACCO CIGARS	18.3	19.7	17.9	19.1	19.4	21.3
ALCOHOL	21.2	21.3	19.5	20.1	23.1	22.7
	16.5	17.5	16.3	16.6	16.6	18.3

^a Low precision, no estimate reported.

^b Not available.

NOTE: Past Year Initiates are defined as persons who used the substance(s) for the first time in the 12 months prior to date of interview.

^c Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.

^d Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

¹ Illicit Drugs include marijuana hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

² Nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, or sedatives; does not include over-the-counter drugs.

³ Daily Cigarette Use is defined as ever smoking every day for at least 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003 and 2004.

Attachment 3

How Community Anti-Drug Coalitions Deal With Methamphetamine

Community anti-drug coalitions deal with the methamphetamine issue in a coordinated, comprehensive and data-driven manner. They collect and analyze baseline data to identify and address the methamphetamine problem. This is collected from student surveys, law enforcement, prisons, jails, retail stores, treatment and other social service providers. Coalitions use this data to determine and implement a comprehensive array of evidence based strategies and programs to best prevent and address the methamphetamine problems in their communities. They recognize that all sectors of the community (*e.g.*, schools, law enforcement, parents, businesses, etc.) must be involved if they are to successfully prevent and combat methamphetamine. The programs, strategies, and activities that coalitions have implemented to combat methamphetamine include:

- Building community awareness by educating citizens as to how to identify and report methamphetamine activity;
- Supporting methamphetamine awareness trainings (attended by real estate agents, property managers, substance abuse counselors, school personnel, health care professionals, ambulance, law enforcement personnel, hotel/motel managers, local service clubs, firemen, judges, business groups, parents, probation, and citizens) that provide details about how to identify methamphetamine labs and dump sites, and how to identify when someone may be under the influence of methamphetamine;
- Providing emergency personnel with current information for the recognition of methamphetamine and how to respond;
- Providing training to social workers and others who enter homes where methamphetamine activity may take place;
- Providing targeted education and peer resistance skills to youth within the community by partnering with programs such as the Safe and Drug Free Schools and Communities program to ensure that effective prevention curricula and programming are implemented at the school level;
- Providing community members with resource materials, including methamphetamine prevention kits;
- Supporting the implementation of drug-endangered children programs;
- Supporting local methamphetamine summits for concerned community members, often attended by hundreds of local residents;
- Supporting collaboration between local law enforcement and retail merchants to address theft of precursor chemicals and “suspicious” methamphetamine -related purchases;
- Supporting methamphetamine tip lines to inform law enforcement of methamphetamine problems; and
- Finding the resources needed for communities to quickly implement proven strategies to combat methamphetamine

Examples of How DFC Grantees Have Successfully Reduced Methamphetamine Use

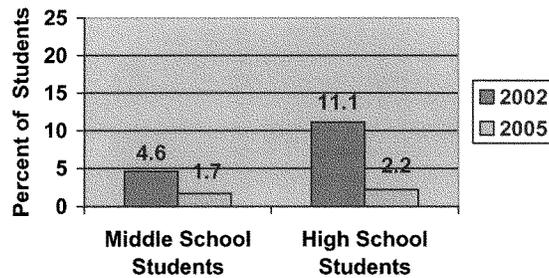
Community Anti-Substance-Abuse Efforts Coalition, Bonifay, Florida

The Countywide Anti Substance-Abuse Efforts (CASE) Coalition in Bonifay, Florida has implemented multiple strategies to reduce substance use among youth, utilizing a multi-sector approach, including, but not limited to: the health department; Holmes County School Board and school principals; law enforcement; parents; youth; the Board of County Commissioners; Clerk of the Court and other court officials; area treatment providers; the Department of Juvenile Justice; members of the business community; and religious institutions.

As a result of its multi-sector approach, the CASE Coalition has contributed to impressive reductions in methamphetamine use within the community. For example, the number of middle school students reporting lifetime use of methamphetamine decreased at a rate of 63.0%, from 4.6% in 2002 to 1.7% in 2005. The number of high school students reporting lifetime use of methamphetamine decreased at a rate of 80.2%, from 11.1% in 2002 to 2.2% in 2005.

To achieve these impressive results, the CASE coalition implemented an array of comprehensive, data driven strategies, including, but not limited to: providing community-wide methamphetamine awareness and education presentations; initiating anti-methamphetamine forums, press releases and direct mailings to key business and community leaders about methamphetamine; establishing a local anti-methamphetamine advertising campaign; creating and disseminating a Methamphetamine Awareness Neighborhood Resource Guide to all households within the county; and establishing and providing support for neighborhood watch groups that the Holmes County Sheriffs Department identified as the highest crime/arrest areas for methamphetamine.

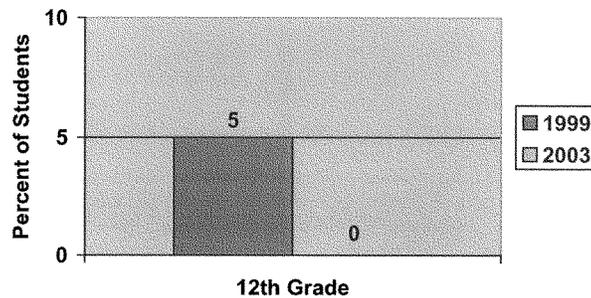
Lifetime Use



Project Radical in Reinbeck, Iowa

Project Radical has achieved impressive reductions in methamphetamine use in Reinbeck, Iowa. It contributed to a decrease in past 30 day methamphetamine use by 12th graders, from 5% in 1999 to 0% in 2003, resulting in a 100% rate of change (American Drug and Alcohol Survey, 2003).

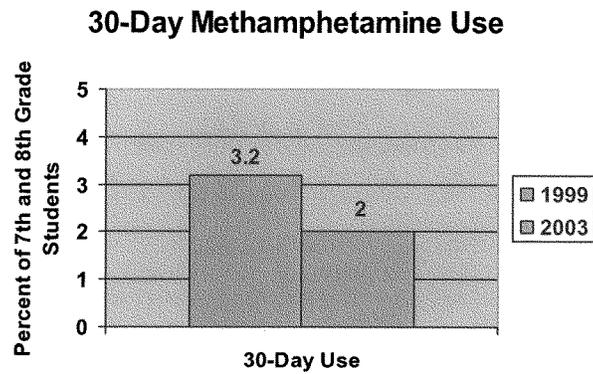
To achieve these results, the Project Radical Coalition collaborated with multiple community partners. In conjunction with SDFSC program coordinators, the coalition developed a state certified mentoring program and became a certified SAFE (Substance Abuse Free Environment) community. Funding from the SDFSC program was also used to purchase and implement science-based curricula for the Strengthening Families, Project Alert and Life Skills Training prevention programs. Through collaboration with community members, local businesses and law enforcement officials, Project Radical was able to implement the MethWatch program in their community. The MethWatch program promotes cooperation between retailers and law enforcement to curtail the theft and suspicious sales of products used to manufacture methamphetamine. In addition, the cooperation of multiple community sectors also helped to create the Get a Grip program, which focuses on youth substance abuse screening, intervention and treatment referrals.

30-Day Methamphetamine Use

Phillips County Coalition for Healthy Choices in Malta, Montana

Another example of the significant outcomes that can be achieved when multiple community sectors, including schools, law enforcement, parents, the media and service organizations, collaborate to address methamphetamine use is the Phillips County Coalition. This DFC grantee contributed to reducing the number of 7th and 8th graders in Phillips County, Montana who reported using methamphetamine in the last 30 days at a rate of 37.5%, from 3.2% in 1999 to 2.0% in 2003. This is a significant reduction when considering that the average 30 day use of methamphetamine in middle schools throughout the state of Montana is 4.6%.

To achieve these successes the coalition implemented numerous strategies aimed at the reduction of methamphetamine use, including: 1) school-based activities; 2) public service announcements; 3) collaborating with the media to expand local news coverage on this issue; 4) parent education; and 5) community-wide training opportunities to provide the public with accurate information about the effects of methamphetamine production and use.



Attachment 4

Significant Methamphetamine Outcomes from the State Grants Safe and Drug Free Schools and Communities Program

The SDFSC program has capitalized on the fact that it has unprecedented access to school-aged youth throughout the country and is providing them and their parents/caregivers with the information and education necessary to reduce methamphetamine use. As a result, SDFSC programs throughout the country have achieved significant results in reducing youth methamphetamine use.

California – Between 1997 and 2002 the California SDFSC program contributed to a decrease of 52.9% in past 30 day methamphetamine use among 9th graders. In 1997, 3.4% of respondents reported using methamphetamine in the past 30 days, while in 2002 only 1.6% of respondents had used methamphetamine for the same time period (California Student Survey, 1997 & 2002).

Florida – Florida's SDFSC program contributed to a decrease of 50.0% in lifetime methamphetamine use among 12th graders, down from 2.8% in 2001 to 1.4% in 2005 (Florida Youth Substance Abuse Survey, 2005).

Hawaii – Between 1998 and 2002 the Hawaii SDFSC program contributed to a decrease of 37.3% in lifetime methamphetamine use among 10th graders. In 1998, 6.7% of respondents reported using methamphetamine in their lifetime, while in 2002 only 4.2% of respondents had used methamphetamine in their lifetime (Hawaii Student Alcohol, Tobacco and Other Drug Use Study, 2002).

Idaho – Between 1996 and 2004 the Idaho SDFSC program contributed to a decrease of 51.9% in lifetime methamphetamine use among 12th graders. In 1996, 10.4% of respondents reported using methamphetamine in their lifetime, while in 2004 only 5.0% of respondents reported methamphetamine use in their lifetime (Idaho Survey, 1996 and SDFS Survey, 2004).

Kansas – Kansas' SDFSC program contributed to a decrease of 54.3% in past 30 day methamphetamine use among 8th graders, down from 2.2% in 1997 to 1.0% in 2003 (Kansas Communities that Care Survey, 2003).

Maine – Between 2000 and 2004 the Maine SDFSC program contributed to a decrease of 57.9% in lifetime use of methamphetamine among 8th graders, from 5.7% in 2000 to 2.4% in 2004. Similarly, it contributed to a decrease of 56.2% in lifetime methamphetamine use among 12th graders, from 14.6% in 2000 to 6.4% in 2004 (The Maine Youth Drug and Alcohol Use Survey, 2004).

Massachusetts – Between 1999 and 2003 the Massachusetts SDFSC program contributed to a decrease of 44.1% in lifetime methamphetamine use among 11th graders. In 1999, 9.3% of respondents reported using methamphetamine in their lifetime, while in 2003 only 5.3% of respondents reported methamphetamine use in their lifetime (Youth Risk Behavior Survey Results for Massachusetts, 2003).

Pennsylvania – Between 2001 and 2003 the Pennsylvania SDFSC program contributed to a decrease of 31.8% in lifetime methamphetamine use among 12th graders. In 2001, 4.4% of respondents reported using methamphetamine in their lifetime, while in 2003 only 3.0% of respondents had used methamphetamine in their lifetime (Pennsylvania Youth Survey, 2003).

Washington – Between 2000 and 2002 the Washington SDFSC program contributed to a decrease of 17.2% in lifetime methamphetamine use among 12th graders. In 2000, 2.9% of respondents reported using methamphetamine in their lifetime, while in 2002 only 2.4% of respondents reported using methamphetamine in their lifetime (Washington's Healthy Youth Survey, 2000 & 2002).

Vermont – Vermont's SDFSC program contributed to a decrease in lifetime methamphetamine use of among 11th and 12th graders by 28.5% and 33.3% respectively. In 2001 7.0% of 11th graders and 9.0% of 12th graders reported ever having used methamphetamine. In 2005 those statistics went down to 5.0% and 6.0% respectively (Youth Risk Behavior Survey Results for New Hampshire, 2005).

Attachment 5

**Twenty Percent Governor's Set Aside From the State Grants portion of the SDFSC
Program Addresses Methamphetamine**

Many states experiencing severe methamphetamine problems are using funds from their Governor's set asides to set up methamphetamine task forces at the state and community levels.

Washington State Meth Action Teams

In 2003 county "Meth Action Teams," a statewide infrastructure, were put into place to impact the methamphetamine problem in each county in Washington. Four counties joined together in consortia resulting in 37 Meth Action Teams (MATs) within the 39 Washington State counties.

Local MATs were implemented using the existing "Community Mobilization Against Substance Abuse and Violence" program structure in each county. The Community Mobilization (CM) Program came into existence in 1989 as a result of Washington's Drug Omnibus Act of 1989. To impact the methamphetamine problem in their communities, local MATs are co-convened in each county by the county sheriff and the CM coordinator. They undertake a multi-pronged approach, including law enforcement, prevention, and treatment.

The current MATs are reflective of their rural/urban communities and typically include the following representatives who work together to address the methamphetamine problem within each county:

- | | |
|---|---|
| • Media | • Medical/dental |
| • Law enforcement | • Neighborhood leaders |
| • Health Department (public health) | • Concerned community members |
| • Child Protective Services | • Local elected officials |
| • Treatment | • Corrections |
| • Business | • Prosecution |
| • Retailers (drug store pharmacies and agriculture) | • Ecology |
| • Education (school districts, educational service districts) | • Customs/Immigration Naturalization Services |
| • Youth | • Alcohol, Tobacco and Firearms |
| • Realtors/landlords | • Legislative aides |
| • Local government (city, county) | • Congressional aides |

These county MATs conduct the following activities to address methamphetamine production and abuse within their counties:

- | | |
|---|---|
| • Retailer education concerning sales of precursor chemicals (drugstore, pharmaceutical, farm supply, supermarkets, convenience stores, | pharmacies, and hardware stores) |
| | • Address dumping of methamphetamine waste in rural, isolated areas |

- Neighborhood block parties and other community education events concerning methamphetamine issues
- Law enforcement education
- Collaboration between law enforcement and retail merchants to address theft of precursor chemicals and “suspicious” methamphetamine -related transactions
- Production of methamphetamine education materials for community members in English, Spanish, Korean, and Laotian
- Methamphetamine awareness trainings for real estate agents, property managers, substance abuse counselors, home visitors, hotel/motel managers, local service clubs, firemen, judges, business groups, parents, probation, and citizens. Trainings explain how to identify methamphetamine labs and dump sites, and how to identify when someone may be under the influence of methamphetamine.
- Educational media in rural counties including newspaper ads, television commercials, and local cinema, as well as 4-H events and “sobriety camp” for families on tribal lands
- Educational outreach to elementary school children
- Farmer education
- Development of volunteer speakers’ bureaus to continue community
- Methamphetamine “tip” lines to inform law enforcement of methamphetamine problems
- Physical impacts of methamphetamine on the abuser
- Identify theft and it’s relationship to methamphetamine abuse
- Adopting laws to reduce availability of methamphetamine precursors
- Children endangered by drug labs and drug use
- Development of drug-endangered children protocols for social services, law enforcement and child protective services to follow when children are found in labs
- Promotion and recruitment of foster families for drug-endangered children
- Drug courts for juveniles
- Local methamphetamine and youth Summits for community members

Idaho Meth Task Force

The State of Idaho has used a portion of its 20% Governor’s set aside to address methamphetamine, and has developed a Meth Task Force comprised of community members throughout the state to address this issue. A primary goal of the Task Force is to develop and distribute methamphetamine tool kits to communities in the state. These kits will include videos, charts, posters, brochures and various informational articles focusing on methamphetamine prevention. In recent years, Idaho has seen great decreases in the prevalence of methamphetamine use. For example lifetime use of methamphetamine among 12th graders decreased at a rate of 51.9%, from 10.4% in 1996 to 5.0% in 2004. Similarly,

lifetime use of methamphetamine among 10th graders has decreased by 41.0%, from 6.9% in 1998 to 4.6% in 2004.

Ohio Resource Network

The Ohio Resource Network (ORN) is funded in part with Title IV Safe and Drug Free Schools dollars. This year, it invested \$10,000 in delivering four regional workshops on methamphetamine prevention and drug exposed children; three sessions have been conducted thus far, which have attracted 99 participants from law enforcement, education, and social services agencies.

ORN also coordinates an early warning network. In October of 2004, an alert was released on methamphetamine to approximately 1,400 professionals from law enforcement, juvenile justice, education, health, and social services who serve as points of contact in their community. Recipients often forward the alerts on to persons and places where it can really be used—in a survey of recipients last year, we learned it was eventually distributed to more than 19,000 people.

Mr. SOUDER. Mr. Brooks.

STATEMENT OF RON BROOKS

Mr. BROOKS. Chairman Souder, Ranking Member Cummings, Congresswoman Watson, thank you for inviting me to discuss the Synthetic Drug Control Strategy. This strategy is a welcome development from the administration, but, on behalf of the 62,000 law enforcement officers I represent as the president of the National Narcotic Officers' Associations' Coalition I have concerns about serious shortcomings which may put the laudable goals of this strategy in jeopardy.

The strategy is an important first step, but why did it take so long for ONDCP to prepare it? Why weren't more partners consulted in its development? The strategy is not supported by original and meaningful recommendations for action. Without action and, more importantly, without buy-in from key stakeholders, the Synthetic Drug Control Strategy is in danger of becoming irrelevant before it has a chance to succeed.

In 1995, California was inundated with meth. After I alerted DEA and ONDCP leadership, they convened a series of stakeholder meetings that resulted in the first methamphetamine strategy by the Department of Justice. Collaboration continued and progress was being made on the West Coast, but meth was slowly creeping eastward. As meth began to overrun the Midwest and Appalachia, by 2001 collaboration with ONDCP began to wane. By 2004, groups across the country were calling for help from Congress; and Congress responded to their constituents by drafting the Combat Meth Act, which passed earlier this year.

While the NNOAC and other key stakeholders worked closely with Congress to refine and pass this legislation, ONDCP was absent. I personally heard complaints from staff that they could not get assistance from ONDCP despite repeated attempts to obtain their support.

Attorney General Gonzales broke the administration's silence on meth on July 18, 2005, when he said, in terms of damage to children and to our society, meth is now the most dangerous drug in America.

Shortly thereafter, an ONDCP spokesperson wrote off the focus on meth by saying that people are crying meth because it is a hot new drug.

Of course people were crying meth. But those of us in law enforcement, treatment and prevention knew that we were facing a problem that was growing worse by the day. Cops, doctors, treatment providers, DAs, child protective agencies and community coalitions were being overwhelmed by meth problems in many parts of our Nation. They weren't crying meth just to make noise. They were asking for help. ONDCP not only ignored them, they even tried to tell them that they didn't really have a problem.

This is inexcusable, Mr. Chairman; and this Synthetic Drug Control Strategy continues to reflect ONDCP's disregard for the experience and perspective of the experts on the ground.

If the NNOAC had been consulted by ONDCP, we would have made the following recommendations: Support law enforcement task forces that have seized thousands of meth labs by fully fund-

ing the Byrne Justice Assistance Grant program at the currently authorized \$1.1 billion level.

Fund the COPS Methamphetamines Hot Spot program, which has provided resources to hard-hit areas to train, equip and mobilize law enforcement resources to address the meth issues.

Call on Congress to authorize the Center for Task Force Training at the Bureau of Justice Assistance, which provides much-needed training for drug task force commanders and meth investigators.

Ensure that the OCDETF Fusion Center is coordinated with Regional Information Sharing Systems and the HIDTA Intel Centers and ensure that the OCDETF Fusion Center follows the guidelines of the National Criminal Intelligence Sharing Plan which was implemented by the Department of Justice.

State and local drug task forces funded through Byrne were responsible for seizing 5,400 meth labs in 2004 alone. How effective is a strategy that establishes lab seizures as a goal and then takes away funding from the Byrne-funded task forces that make a large percentage of those seizures? Less law enforcement equals fewer labs seized. That is not success. That is surrender.

The strategy states that the administration will continue to partner with State, county, tribal and city governments over the next 3 years to attack the illicit use of methamphetamine. Yet the administration has proposed in the past 2 years to disengage from State and local partnerships by recommending termination of key assistance and training programs such as Byrne, JAG, COPS Hot Spots and the Center for Task Force Training.

Paying lip service to the importance of Federal, State local law enforcement partnerships without putting resources and actions behind the words is a recipe for a failed Synthetic Drug Control Strategy.

Mr. Chairman, I have always believed that treatment, education and prevention hold the keys for reducing America's drug problem. As long as drug traffickers ply their trade, narcotics officers will be there to stop them. Clinically appropriate treatment must be made available, but stopping use before it starts should be our ultimate goal. The things I have seen meth addicts do to themselves and others would make members of this subcommittee cringe. Collectively, we must do all we can to prevent first use, but the synthetic strategy fails to address prevention in a comprehensive way.

Community Anti-Drug Coalitions are critical. Effective school-based anti-drug curriculum is important. Aggressive enforcement against drug producers and traffickers is absolutely essential.

ONDCP has had an opportunity to really step up to the plate by issuing a strategy. I am truly disappointed that it provides little new strategic direction to address the meth problem. I am hoping that, with the continued leadership of this subcommittee, the strategy will be re-thought in a collaborative environment with input from all of the key constituents and that a new, more robust, well-thought-out Synthetic Drug Control Strategy will be the result.

Thank you.

[The prepared statement of Mr. Brooks follows.]

STATEMENT FOR THE RECORD

Ronald E. Brooks, President

National Narcotic Officers' Associations' Coalition (NNOAC)

“Evaluating the Synthetic Drug Control Strategy”

Hearing Before the

Subcommittee on Criminal Justice, Drug Policy, and Human Resources

Committee on Government Reform

United States House of Representatives

June 16, 2006

INTRODUCTION:

Chairman Souder, Ranking Member Cummings, Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the recently released Synthetic Drug Control Strategy (SDCS). This strategy is a welcome first step from the administration, but there are serious shortcomings which may put the laudable goals of the strategy in jeopardy.

I am the President of the National Narcotic Officers' Associations' Coalition (NNOAC), which represents 44 state narcotic officers' associations with a combined membership of more than 62,000 police officers throughout the nation. I am a veteran police officer and have spent the vast majority of my thirty-three year law enforcement career assigned to

drug enforcement. Last year I retired from state service as an Assistant Chief with the California Department of Justice, Bureau of Narcotic Enforcement and continue to serve in law enforcement as the Director of the Northern California High Intensity Drug Trafficking Area (NC HIDTA).

Methamphetamine and the abuse of prescription drugs pose significant threats to the safety of every community in America. Despite the danger posed by global terrorism, no child in America has been killed as a result of a terrorist attack since September 11, 2001. Unfortunately, every child in our great nation will be exposed to illicit drugs through friends, family and schoolmates. The pervasive availability of methamphetamine and prescription drugs such as Xanax, OxyContin, Vicodin, Soma and steroids, will tempt many children to make that devastating choice to risk their life, liberty and future by using these and other powerful drugs of abuse.

The threat of synthetic drug abuse dates back to before the turn of the century when patent medicine was sold without prescription by druggists traveling throughout the nation resulting in per-capita drug addiction rates that rival those of today. But drug laws, beginning with the Harrison Act of 1914 and a strong anti-drug message worked to control the threat. We are once again faced with the threat of synthetic drugs as methamphetamine is manufactured in clandestine laboratories throughout the nation and from methamphetamine manufactured in Mexico and spilling across our porous border in record amounts. Synthetic prescription drugs and steroids are readily available on the Internet without a doctor's prescription and are also available from unregulated

pharmacies in Mexico. And Fentanyl has once again surfaced in Chicago, Philadelphia, the Midwest, Northeastern and California, resulting in a spike in overdose deaths.

Unfortunately, the widespread availability of powerful, highly addicting drugs poses as great a threat today as anytime in our nation's history. During my career I have personally witnessed every drug use trend including methamphetamine, crack cocaine, PCP and LSD that our nation has experienced in the past thirty-three years. I seized my first meth lab in 1981 and since that time I have investigated several hundred meth labs and/or meth distribution organizations. Those labs and organizations have ranged from the very small to some of the largest and most sophisticated labs seized in the United States. I have seen firsthand the death, lost opportunities, devastation, violent crime and environmental destruction that drug use brings to our cities and towns. Despite the danger posed by all drugs of abuse, I have never seen a drug cause more devastation to users and their families than methamphetamine. This highly addicting drug robs families of their children, young people of their dreams and our country of the bright minds and sound bodies that we must rely upon to remain strong. Methamphetamine causes parents to choose the drug over the safety and welfare of their children. In communities where meth use is prevalent, as much as 85% of the child abuse and endangerment is attributed to meth use. And highly toxic meth labs threaten neighbors and the environment with the carcinogens that are used in the volatile process of manufacturing this poison.

On June 8, 2006 I attended the Vigil for Lost Promise, which was the vision of Ginger Katz who lost her son Ian to a heroin overdose. Ginger, along with six other parents who

had lost children, and Drug Enforcement Administration Administrator Karen Tandy co-sponsored this moving event to focus attention on the devastating effects of drug abuse. Seeing the faces of those who had lost their lives to drug use as they were flashed upon the screen during the vigil and seeing the pain that each surviving family member was experiencing as they relived those personal tragedies brought back hundreds of personal memories of delivering death notices to parents who had lost a child a drug overdose or a drug related traffic collision. It also brought back the feeling of despair that occurred each time I raided a drug house and found innocent young children being raised with the danger and hopelessness that is an everyday part of the drug lifestyle. That June 8th Vigil reminded me why the mission of America's narcotic officers is so important and why we must all work together for sound drug policies to protect our children from the cruelty and misery of drug abuse.

**SYNTHETIC DRUG CONTROL STRATEGY DEVELOPED WITHOUT
CONSULTATION WITH KEY GROUPS:**

The Synthetic Drug Control Strategy (SDCS) strategy is an important step toward protecting our children. I know that much work went into the development of this strategy by the Office of National Drug Control Policy (ONDCP), which took the lead on this project along with the Department of Justice (DOJ) and Health and Human Services (HHS). But the question must be asked: why did it take so long to decide to prepare a strategy and why more partners were not consulted in a collaborative development of the SDCS. This plan – although a move in the right direction – does not represent a strategy supported by concrete actions. Like many other strategies developed by ONDCP, it was

written with little or no substantive input to ONDCP from the key constituencies who will be charged with executing it. Without action – and lacking buy-in from the stakeholders – the Synthetic Drug Control Strategy is in danger of becoming irrelevant before it has a chance to succeed.

In the early 1990s California narcotic officers were witnessing an explosion in the number of clandestine methamphetamine labs that were being seized throughout the state. At the same time, communities throughout the West and Midwest were experiencing record numbers of meth related overdoses, emergency room admissions, domestic violence, child abuse incidences and other indicators that meth use was rapidly on the rise. An interesting phenomenon noted by California narcotic officers was a transfer of meth production from the Hells Angels and other outlaw motorcycle gangs to drug organizations controlled by Mexican Nationals using ephedrine and pseudo-ephedrine as the primary precursor chemical rather than phenyl 2 propanone (P2P) and methylamine. This change in manufacturing procedure resulted in a more powerful and addicting form of the drug.

In 1995, as the President of the California Narcotic Officer's Association, I conducted briefings on this emerging drug threat for then-DEA Administrator Tom Constantine, then-ONDCP Director Barry R. McCaffrey, and Senator Dianne Feinstein. The "Precursor Control Act" of 1996, sponsored by Senator Feinstein, grew directly out of that first briefing. Administrator Constantine responded immediately to the threat and hosted the first International Methamphetamine Conference where members of law

enforcement, treatment and prevention came together to learn more about the emerging meth problem and its deadly consequences.

I had the privilege to serve as one of the curriculum co-chairs for the meth strategy conference. Following two days of informative plenary sessions, attendees participated in topical break-out sessions which were facilitated and recorded. The results of those collaborative break-outs and the presentations by subject matter experts resulted in the publication of the Department of Justice and DEA's National Methamphetamine Strategy. These were good plans – developed in a collaborative manner with buy-in from several stakeholder groups – but at the time they were developed, the meth problem remained geographically limited.

The DEA meth conference was followed by ONDCP's Western States Meth conference. That summit followed a similar format of presentations by experts and collaborative sessions to further develop ONDCP's response to the meth problem. At that conference, during their respective presentations, Senator Feinstein, Director McCaffrey and Administrator Constantine each credited me and my California law enforcement colleagues with being the first to ring the bell on this emerging drug trend. By then, meth was beginning to spread eastward because international DTOs were using their existing heroin and cocaine distribution networks. Working narcotic officers – not bureaucrats from within the Beltway – had the accurate, first-hand knowledge that shaped the initial national response to the problem.

Unfortunately, since 2001 this collaborative effort has disintegrated. Since 2001 I can only recall being invited to two constituent group meetings to discuss drug policy issues. My organization, along with many others including ONDCP's own HIDTA Directors, are rarely consulted and never included in any type of collaborative process when addressing emerging issues, developing policies or preparing major strategic documents. Not only were the NNOAC and HIDTA Directors not consulted by ONDCP for the development of the SDCS, we were not consulted on the development of last year's Synthetic Drug Action Plan or the Southwest Border Strategy.

An excellent example of how law enforcement can serve as a barometer to warn of emerging drug threats and to assist in developing responses to those threats is the current explosion in Fentanyl use and related overdose deaths. The first three intelligence bulletins describing the nature of the emerging Fentanyl problem were prepared and distributed by the San Diego (CBAG) Chicago and Philadelphia HIDTAs. To follow up on the threat, the Chicago HIDTA, Chicago Police Department and DEA are hosting a conference to allow agencies that are being impacted by this problem to discuss the scope of the threat and strategies for addressing it. I was glad to see the major Fentanyl lab bust in Mexico last week, and I'm afraid that's the tip of the iceberg.

One of the three main goals of the strategy is to significantly reduce domestic labs, yet this strategy comes as the domestic meth lab problem has already dramatically declined. Thanks to proactive steps by progressive states, and thanks to Congress ensuring that harmful budget recommendations are not followed, clandestine domestic meth seizures

continue to decline. Just yesterday Minnesota announced a reduction of more than 70% in meth lab seizures.

The Combat Meth Act, passed by Congress as part of the PATRIOT Act reauthorization earlier this year, created a much-needed national standard. Unfortunately, while the NNOAC and other key stakeholders worked closely with congressional staff to write, refine and seek passage of this important legislation, ONDCP was nowhere to be found. I personally heard complaints from many key House and Senate staff members that were working on this legislation stating that they could not get any form of assistance from ONDCP despite repeated attempts to obtain that support. The Combat Meth Act, perhaps the most important anti-meth legislation to date, was shaped and enacted without input and in some cases over the objections of ONDCP.

ONDCP HAS NOT DEMONSTRATED INTEREST IN THE METH PROBLEM:

Since 2001, ONDCP has seemed very reluctant to be engaged on the meth issue and even less likely to support the efforts of – or acknowledge the expertise of – state and local law enforcement officers. Despite extensive attention by the media, legislative action by many local communities, states and the Congress over the past five years, ONDCP leadership was inexplicably mute on the subject of meth. Much was being done by ONDCP's twenty-eight High Intensity Drug Trafficking Areas (HIDTA) to address the meth threat in their regions. Under the leadership of Deputy Director Scott Burns, ONDCP's Office of State and Local Affairs was working hard to support each HIDTA's meth enforcement efforts. Despite this, little or no leadership was received from the

ONDCP Director. And this lack of focus relative to meth was not only true with enforcement activities. The leadership of ONDCP also seemed to need prodding to address the meth epidemic in the Youth Media Campaign. True, the national stats on meth use are relatively low, but to look only at the national numbers without considering regional impact or the unique nature of the drug is to ignore critical facts.

While I have serious concerns regarding budget priorities for justice assistance programs in the President's budget, I can say that the efforts of the United States Department of Justice, especially the Drug Enforcement Administration and the Bureau of Justice Assistance, have been more encouraging than the efforts of ONDCP. It was not until Attorney General Alberto Gonzales spoke out on the meth threat that started paying more attention. Attorney General Gonzales broke the administration's silence on meth in a speech to district attorneys on July 18, 2005. He said "in terms of damage to children and to our society, meth is now the most dangerous drug in America." Shortly thereafter, an ONDCP spokesman wrote off the focus on meth by saying that people are "crying meth because it's a hot new drug." Of course people were crying meth, but those of us in law enforcement, treatment and prevention knew that we were not facing a new problem – we were facing a problem that was growing worse by the day. Those persons that were calling attention to the meth problems were the cops, emergency medical technicians, treatment providers, drug court judges and community based prevention coalitions that were being overwhelmed by the meth problem in many parts of the country. These were real authorities with real responsibilities, real addicts and real meth labs on their hands. They weren't "crying meth" just to make noise; they were asking for help. ONDCP not

only ignored them, they even tried to tell them that they didn't really have a problem.

This is inexcusable, Mr. Chairman, and this Synthetic Drug Control Strategy continues to reflect ONDCP's disregard for the experience and perspectives of the experts on the ground.

Where was the Drug Czar – our nation's primary spokesperson on the threat of drug abuse – on this issue when most Americans, either through first-hand experience or exposure through the media knew the seriousness of the threat posed by meth? Why are we just now releasing this synthetic drug strategy, when the problem was pervasive and well-known in 2001? I believe the answer is that ONDCP has been out of touch when it comes to meth.

This strategy was formed without the consultation of the National Narcotic Officers' Associations' Coalition, the National HIDTA Directors, the National Alliance of State Drug Enforcement Agencies, or many other groups representing treatment, prevention, and law enforcement. Although there are some references to consulting with HIDTA Directors and the NNOAC, I can assure you that the consultation referred to consisted only of seeking seizure and other statistical data. Mr. Chairman, even though you and the members of the subcommittee and your staff have developed significant expertise in drug policy and criminal justice issues you still hold hearings to become better informed on the specific issues that you are addressing. I am also in frequent contact with your staff and staff members from throughout the Congress as they work on drug policy issues. It is unfortunate that ONDCP has not taken a cue from you and your colleagues to use the

same system of collaboration as they tackle these difficult and complex drug policy issues. Regrettably, there was never a collaborative process where ONDCP sat down with the practitioners in state and local law enforcement, as had prior ONDCP administrations. Sadly, it appears to me that the preparation of this critically important strategy was prepared in a Washington D.C. vacuum while ignoring the experience of the 62,000 law enforcement officers represented by the NNOAC, the 33 HIDTA Directors and I suspect members of other key constituent groups.

If the NNOAC had been consulted by ONDCP, we would have made the following key recommendations:

- Fully fund the Byrne Justice Assistance Grant formula program that has been responsible for thousands of meth lab seizures at the authorized level of \$1.1 billion (authorized in the Department of Justice Appropriations Authorization Act of 2006);
- Fund the COPS Methamphetamine Hot Spots program, which has provided valuable resources to scores of particularly hard-hit jurisdictions to train, equip, and mobilize law enforcement resources to address the meth production and addiction problem;
- Urge Congress to authorize the Center for Task Force Training (CenTF) at the Bureau of Justice Assistance (BJA), which provides essential and much-needed training for drug task force commanders and methamphetamine investigators;
- Ensure that the OCDETF Fusion Center that is referenced in the strategy is coordinated with the Regional Information Sharing Systems (RISS) centers and

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the HIDTA Intelligence Centers, and ensure that the OCDETF Fusion Center follows the National Criminal Intelligence Sharing Plan guidelines developed by the Global Intelligence Working Group at the Bureau of Justice Assistance.

SPECIFIC PROBLEMS WITH THE SDCS:

While the release of this strategy is a positive step, the lack of collaboration with state and local entities stakeholders has resulted in serious flaws in the strategy which call into question its viability.

The Synthetic Drug Control Strategy talks about training law enforcement, yet the administration's FY 2007 budget request, supported by ONDCP, eviscerated the primary meth enforcement and meth related training programs for state and local law enforcement, including the Byrne Justice Assistance Grant program, Community Oriented Policing Services (COPS) Hot Spots, and the Bureau of Justice Assistance's Center for Task Force Training (CenTF). ONDCP had also supported those same budget cuts last year along with significant cuts to the HIDTA Program. It is difficult to believe that the leadership at ONDCP truly wants to address the meth problem if they openly support cuts to programs that fund training and enforcement activities for state and local law enforcement when it is those state and local cops that account for 97% of all drug arrests in America including those associated with methamphetamine manufacturing and distribution.

State and local drug enforcement task forces funded through the Byrne Justice Assistance Grant (JAG) program were responsible for seizing over 5,400 meth labs in 2004 alone. HIDTA Initiatives were also responsible for seizing significant numbers of meth labs and HIDTA Intelligence Centers provided much needed intelligence support and coordination to target lab operators and complex meth drug trafficking organizations. How could the authors of this strategy possibly ignore the reality that more than one third of all meth lab seizures were conducted by Byrne-funded task forces, and strongly support recommendations by OMB to eliminate the Byrne JAG program?

How effective is a strategy that establishes lab seizures as a goal and then takes away funding from the law enforcement programs that make these seizures? How can law enforcement be expected to accomplish a goal when their basic tools are taken from them?

The strategy states that “The production and use of methamphetamine and the non-medical use of controlled substance prescription drugs are among the Administration’s foremost concerns related to illicit drugs.” Yet ONDCP leadership has consistently led Congress and stakeholders to believe otherwise by ignoring pleas to deal with the issue.

In discussing measurement of the strategy’s effectiveness, the strategy states that monitoring of arrests, Southwest border seizures, and treatment admissions related to synthetic drugs will not be considered indicative of synthetic drug usage. I understand the point as it relates to usage rates, but the statement has the effect of discounting the

importance of law enforcement activities. In the wake of dramatic declines in domestic meth labs, law enforcement across the country is reporting a surge in Mexican-produced meth being trafficked into new regions. Given that reality, Southwest border seizures and overall synthetic drug-related arrests MUST be key pieces of the strategy, and the measurements of those activities are appropriately indicative of law enforcement's effectiveness in addressing the synthetic drug problem.

With regard to the strategy's stated goal of reducing domestic methamphetamine laboratories by 25 percent between 2005 and 2008, why isn't the same logic applied here as is applied to arrest and quantity seizure numbers mentioned above? Seizure of domestic labs is dependent in part upon law enforcement presence: if law enforcement reduces resources dedicated to seeking and seizing labs, then we will see fewer labs seized. Less enforcement equals fewer labs seized. That is not success, it is surrender.

If the administration wants to reduce lab seizures, it is already following a good strategy – take away the Byrne-JAG drug task forces and I guarantee you will have fewer lab seizures. If you take away those Byrne-funded task forces, you will have lower meth lab seizure statistics, but you will have made no impact on the problem. The meth supply will continue to grow, as will the toxic meth waste that is being dumped in many neighborhoods.

The SDCS states that “the most urgent priority of the Federal government toward reducing the supply of methamphetamine in the United States will be to tighten the

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international market for chemical precursors, such as pseudoephedrine and ephedrine, used to produce meth.” The NNOAC agrees that international precursor control is key to disrupting the flow of methamphetamine to the streets of America and that it must be addressed. The federal government has an inherent responsibility to address it, since it involves international negotiations, monitoring and interdiction operations. Entities such as JIATF South must be utilized to disrupt the precursor market in the Eastern Pacific, Caribbean and Gulf of Mexico. And since the bulk of synthetic drug precursors are manufactured in a handful of facilities in South and Southeast Asian countries and trafficked heavily along the Pacific Rim, JIATF West can play a critical role in assisting partner nation counter-drug forces address the problem and in integrating intelligence and monitoring activities with nations in the region. Intelligence regarding international precursor availability and international DTOs which is gathered domestically and analyzed by DEA, the RISS projects, and HIDTA ISC’s must also be used to properly address this threat.

The strategy discusses trends over the past five years indicating that “small meth labs were collectively gaining and operators of larger labs were losing market share. This was consistent with what communities were reporting: more methamphetamine labs.” When this trend was occurring, law enforcement, treatment, prevention groups, and members of Congress were alerting ONDCP, and yet they stood silent. Congress acted without significant input from the administration (and in some cases in spite of administration attempts to derail certain provisions) to craft and ultimately pass sweeping anti-methamphetamine legislation – the Combat Meth Act.

The NNOAC is grateful to many dedicated members of Congress for their action on the Combat Meth Act. It is having an impact. Restrictions on precursor chemicals were critical because law enforcement resources were tied up with the small-time lab problem. We have to remain vigilant on this front, but we must also act on the reality that most meth is now coming over our international borders.

The trend of superlabs moving to Mexico from California was due in part to stronger precursor interdiction activities such as DEA's Operation Mountain Express, but it was also due in part to aggressive state and local meth enforcement strategies within California. In particular, the California Bureau of Narcotic Enforcement administered the California Methamphetamine Strategy (CALMS), which successfully focused on organizational targets and super lab operators. How were those strategies funded? Through the COPS Hot Spots program, Byrne-funded task forces, and HIDTAs – all programs which the administration wants to cut despite their demonstrated successes.

The strategy states that “the Federal government provides significant assistance to State and local law enforcement in responding to small toxic labs, and will continue to do so....Federal, State, and local governments share responsibility for attacking the large domestic laboratories.” Two reactions: the first statement rings hollow in the wake of two straight years of devastating administration budget requests for state and local law enforcement assistance programs. The second statement is absolutely accurate, but

would be made impossible if the administration's budget recommendations to cut Byrne JAG were followed.

The strategy refers to the OCDETF Fusion Center. The Fusion Center is an important component of intelligence-driven law enforcement, but we must ensure that the OCDETF Fusion Center is coordinated with the HIDTA Intelligence Centers and the Regional Information Sharing Systems (RISS) centers. These existing networks are the backbone of criminal intelligence and information sharing and must be recognized as such. Also, we must ensure that the OCDETF Fusion Center follows the Fusion Center Guidelines and the National Criminal Intelligence Sharing Plan (NCISP) which were developed by the Bureau of Justice Assistance through the Global Intelligence Working Group (GIWG).

In the strategy section entitled "The Domestic Focus on Methamphetamine and Other Synthetics", the SDCS states that "The Administration will continue to partner with State, county, tribal, and city governments over the next three years to attack the illicit use of methamphetamine. State and local partners are crucial in carrying out the Administration's strategy for the synthetic drug problem, utilizing law enforcement, treatment, and prevention." Yes, state and local partners are crucial, but this statement rings hollow. The administration has proposed in the past two years to DISENGAGE from state and local partnerships by requesting termination of key assistance and training programs in the annual budget request such as Byrne JAG, COPS Hot Spots, and the Center for Task Force Training (CenTF).

The strategy sets eleven “Strategic Goals” for working with state policy makers in 2006 and beyond. Two of the goals deal with assistance to state and local governments: “continue law enforcement training”, and “provide resources for methamphetamine lab cleanup, treatment, and prevention.” Achieving these goals is impossible without continuation of programs such as Byrne JAG, COPS Meth Hot Spots, and the Bureau of Justice Assistance’s Center for Task Force Training (CentTF).

Paying lip service to the importance of federal-state-local law enforcement partnerships without putting resources and actions behind the words is a recipe for a failed Synthetic Drug Control Strategy.

The NNOAC is working closely with the Bureau of Justice Assistance to improve meth enforcement capacity on tribal lands. These areas have been devastated by substance abuse and addiction, including most recently methamphetamine. There is a real need for training and equipment to help tribal law enforcement deal with the meth problem, and the NNOAC appreciates BJA’s collaboration on this project and their continued willingness to collaborate on other programs involving the reduction of the drug threat. In fact, a series of focus groups facilitated by BJA are scheduled in the coming weeks to help identify the largest capability gaps and most pressing needs to get much-needed meth programs to tribal lands.

The NNOAC strongly supports the nation's Drug Courts and applauds their inclusion in this strategy. Drug Courts are an important innovation in current drug enforcement and treatment policy. Methamphetamine is a powerfully addictive drug, and treatment of meth addicts, although successful in situations where addicts receive clinically appropriate treatment, is a long-term proposition. We believe that using the coercive power of courts is essential in helping non-violent drug offenders and addicts succeed in recovery.

As I have repeatedly stated over the years, education and prevention incredibly important. As long as drug traffickers ply their trade, narcotic officers will be there to clean up and punish producers and traffickers. But stopping use before it starts should be our ultimate goal. The things I have seen meth addicts do to themselves and to others would make members of this subcommittee cringe. Collectively, we MUST do all we can to prevent first use. Community anti-drug coalitions are critical. Negative social messages through effective media campaigns are important. Aggressive law enforcement against meth producers and traffickers is essential.

To address the growing problem of prescription drug abuse, education and prevention are critical. Legally obtained prescription medications are often misused and diverted. Law enforcement has little role to play before the diversion takes place. Strong prevention messages must reach our children before they start abusing. Clearly, the threat posed by the abuse of powerful prescription drugs will require adequate resources and new strategies as we aggressively address the on-line distribution of drugs in America.

CONCLUSION

This spring I held the hand of my friend – a law enforcement officer – as he died from cancer that resulted from his years of exposure to toxic chemicals at the meth labs he investigated. This exposure to carcinogens occurred years before we were trained on what protective measures must be taken by responding officers. Remediation of meth labs is a critical safety issue for families, neighbors, children, and law enforcement officers, and it must be a priority.

While I don't want to downplay the importance of the Synthetic Drug Control Strategy, I am disappointed that it provides little new strategic direction to address the meth problem. I am hoping that with the continued leadership of this subcommittee and your colleagues in both Houses of the Congress, this strategy will be re-thought in a collaborative environment with input from all of the key constituents and that a new, more robust and well thought out Synthetic Drug Control Strategy will be the result.

Mr. Chairman, Ranking Member Cummings, members of the Subcommittee, I want to thank you for inviting me to share the views of America's narcotic officers. We applaud you for all that you have done to promote sound drug policy. The members of the NNOAC hold you in great esteem and appreciate your service to America.

Mr. SOUDER. Well, when your panel starts out with the Association of Counties saying “had we been consulted” and finishes with the narcotics officer saying “had we been consulted,” you are less impressed with the first panel’s assertion that you were consulted.

Let me ask a broad question, because I am kind of confused that, in Mr. Burns’ testimony, I felt it was very significant that the administration says that they don’t do strategies by subgroups. In other words, we kind of have a general—I am trying to figure out from a private business approach that—normally, what you would have is a sweeping national strategy of things that are in common. But I can’t hardly imagine that you wouldn’t have a substrategy that would have either in two different ways or different components that relate different ways.

So, first, why wouldn’t you have a cocaine strategy, a heroin strategy, a prescription drug strategy, a meth strategy, a marijuana strategy that would then take into account some fundamental things that we are hearing here? For example, cocaine is not everywhere, but it certainly is concentrated. It is a major drug, and it tends to be more urban. Crack tends to be historically younger, but I don’t know. We have an Intelligence Center that does a lot of this kind of stuff. But heroin is a superhuge problem in some cities like Seattle historically and less in others to varying degrees; and then we had it pop up, as it did a few years ago, in Plano or Orlando or different types of things. Oxycontin will pop up in different areas. Why wouldn’t you have then tailored strategies that fit inside your national strategy as a regular course of doing business?

Also, the HIDTAs on the law enforcement side were meant to kind of be regionalized because some of these problems are regional. So if meth pops up as a challenge you would have HIDTAs that dealt with meth. I am kind of baffled by a principle that says we don’t break these out and then work in subgroup.

Let me ask one followup with this. I made kind of a derogatory comment about conferences. I am not against conferences, and I just could not believe that was the primary strategy.

On the other hand, Ms. Green, you outlined some of the—what the purpose of these conferences were, which is hopefully to get very specific on what is needed at the State level, what is needed in coordination. Why wouldn’t that be done before you issued a strategy?

In other words, isn’t that what you think you would do as you approach cocaine, as you approach meth, as you approach each of these types of things, that there would be regional efforts to pull together the principles in wherever these are problems? You would get them together and say what laws do we have on this? What are you doing at the local level? What more can be done at the Federal level? What funding sources do you need? Why wouldn’t you do what they are proposing to do after they issue the strategy before you develop—as a process of developing a strategy and why wouldn’t you be doing this on multiple drugs?

Ms. WATSON. Mr. Chairman, would you yield for a minute to ask a question. I will go on to the floor, and I will take it in writing.

But in listening to this panel on the ground, those of you who are on the ground, it occurs to me, is there an opportunity to evalu-

ate and assess the various programs that are being described by the administration? Do they work? What are the best practices?

I listened very intently to you, Ms. Green. I think you came closer to my concerns.

And, Mr. Coleman, as heading up an organization in northern California, I would like to hear from you as to what actually is going on in various areas of our State, the largest in the Union, and what is working.

Mr. Brooks, what do we need in terms of law enforcement, what kinds of coordination? Because I join my colleagues—you know, we sit here in Washington, and we come up with these plans. We have a vision for where we want to go. But there seems to be a disconnect when it gets down to the local community, and I find my community void of the resources and the programs. We work through our counties in California, and they are not funded to the point they should be to address these programs.

So, my general question, Mr. Chairman, is there some way to evaluate the plans that are coming from the administration, the HIDTA program and all these others so that we then can come back and make decisions as it deals with appropriating funds to some specific local community, their programs?

So I just throw that out. You can respond in writing. This is who I am; and these are broad, general concerns that I have about this whole synthetic drug control program.

Thank you so much, Mr. Chairman. I am going to go on to the floor.

Mr. SOUDER. Thank you.

Ms. Green.

Ms. GREEN. Yes, Mr. Chairman.

The process that you described, if one were to use a rational and logical process for determining what would be the components of a particular strategy, you would follow the particular process that you outlined. Because the purpose of understanding the particular action plans and recommendations and problems and concerns that are going on at the various State and local level is to determine when you do a strategy what it is that is common in terms of overall themes, what is different, as you indicated. Because that difference can be among drugs. It can be among counties. It can be in localities. All of those would have to be taken into consideration.

Then what happens is all of that information helps you determine what the overall themes are, and those become the common principles of the overall strategy. Then you do in very specific action steps and action plans lay out what needs to be done to address the particular differences between the drugs, the particular differences between systems. That would be the rational process.

We have not actually been very successful in persuading ONDCP that they should follow a particular rational process in developing a strategy. We often do not have the opportunity, because we have actually never been consulted in terms of the national drug strategy at all.

Mr. SOUDER. But you do model State drug laws.

Ms. GREEN. We do model State drug laws; and part of our process is actually to assess how these laws are working. Are they working, are there similarities among the different kinds of laws,

are there different options that can have the same theme but maybe vary based upon the needs of State?

Mr. SOUDER. Do States listen to you?

Ms. GREEN. Yes, actually, we work with, at any given time, about 3 different States; and we work with all 50 States on over 40 different drug and alcohol issues.

Mr. CUMMINGS. Just very briefly, I want, first of all, to thank all of you for your testimony. I think it was good that you had an opportunity to sit in the audience and hear the folks that came before you. I am also glad that you had an opportunity to hear our frustration.

There was an amendment on the floor which said that ONDCP should work with and collaborate with folks on the ground. That is incredible. And we are going to continue to do what we can because we realize—again, we are trying to figure out—I tell people, you know, we do not have but so long to be on this Earth, and we do not have time to waste time, and we do not have time to waste money. And if you all are on the ground and you are dealing with these kinds of things on a daily basis in whatever arenas you may be in, it just makes sense to me that this should not be an us and them. It should be all of us working together to achieve these goals in some kind of way.

I just want to thank you all for your willingness to come to the table, and now we just have to get the other folks to come to the table so that we can achieve the things that we need to achieve.

But, again, I want to thank you, and I will have some followup questions, but I will put those in writing.

Mr. SOUDER. The subcommittee will stand in recess for this vote. I plan to reconvene for a couple of additional questions. Thanks.

[Recess.]

Mr. SOUDER. The subcommittee will come back to order.

I had a couple of questions I wanted to finish the hearing with. I appreciate your patience. If I could return to the question of the statewide conferences that are proposed. Is there any assurances of, as to—I have been to many conferences, and some conferences you go and hear speakers and then sit kind of laissez faire how you apply it. And then other conferences, you go, and at the end of the day, there are resolutions that tend to be almost like us trying to negotiate a bill going to the floor depending on how diverse the group is. Then there are other times where it is, you have—it is almost like you have to have a pre-conference group that sets out some things that are more specific that can move to an action plan.

Ms. Green, you outlined in your testimony fairly specific goals for the conference that I didn't hear the same specificity out of the ONDCP. On the other hand, we didn't ask them precisely the same question. Do you believe and do the others believe that there is a way to structure these such that we can in fact get more specific and effective kind of regional plans and specific State plans? Or basically, will this just be a verification of those States that are organized? Indiana has been getting organized; Hawaii has been organized for quite a while. How do you see this evolving? And how can we make sure that it then gets somehow assimilated to a very specific national plan where the threads that are in common that are national, such as crystal meth coming across the border, need for

certain type of treatments, can be nationalized, and things that are regionalized and implemented at regional—can be regionalized? I would like the input of anyone here on how—do you sense that ONDCP is committed to having more than a hand-holding conference? And, second, how can we make it such that it has specific plans?

Ms. GREEN. Mr. Chairman, I will start since we are the ones that the three agencies, the Justice Department, ONDCP, and HHS, have asked to conduct these conferences.

Do I believe there is a way to make these conferences productive and to have them come out with very specific action plans? Yes, precisely because of the very specific process that I outlined. Now, the key to that process, though, is to have those individuals who actually know specifically what is going on at the State and local level can identify the concerns, can identify what is actually working, can identify particular gaps that they are seeing and put that information together. Now, the key to that is that all of the individuals that are on this panel with me are actually going to be involved in those particular conferences. At the same time, we are going to hold four of them in different regions.

At the same time, we are working with certain evaluations and certain specialists, such as Dr. Carnivalie, who has a specialty in being able to help identify certain common themes and certain specific differences that may, for example, apply to one region, for example the southeast region which is more a preventive mode as opposed to the western region which has actually got a great deal of experience on more issues such as clean-up and remediation of meth labs.

So we have a group of State and locals that are going to actually discuss very specific needs, goals, what is happening, what is not happening, what is working, what is not working. They are going to talk to us about the information that they actually have that indicates successes or positive benefits. Some of the type of information that I suggest in my testimony we can't get from the Federal level. And then we are going to work again with a group of individuals who have a base of experience in looking at that information and being able to help assess, what does that mean in terms of similarities, common themes?

Now, as to, do I believe that ONDCP is committed? My experience is that ONDCP is never committed to action. ONDCP is primarily committed to being able to say what they need to say to try to be able to either checkmark something that they believe that they are committed to do; but when it comes to me believing that they are actually committed to action, I'd have to say, historically, I've never actually seen that. Individuals within ONDCP, for example, Scott Burns, yes. I believe he is committed to action. But since he is not the drug czar at this current moment, I couldn't tell you that my experience with ONDCP under this particular drug czar's office suggests that they are going to commit to any action.

Now, one of the things we are doing to offset what I perceive may happen, which may be an attempt to either try to sanitize what comes out of it or somehow the information to inadvertently get lost, my staff and I are actually going to put together the information, work with, as I said, Dr. Carnivalie and others to see what

it says. We are going to retain that information so that we can disseminate it to all the Federal, State and local policymakers and our partners so that everyone is very clear about what is coming out of these.

Mr. SOUDER. Mr. Brooks.

Mr. BROOKS. I would have to agree on that. I want to start by saying that, first of all, they did this all backward. I mean, the conferences should have come before the strategy. In the old days, when we developed the National Drug Control Strategy or the first meth control strategy out of DOJ with DEA and ONDCP, we came together, we had plenary sessions with experts, and then we broke into groups, and we developed action plans in really robust facilitated focused groups that represented all of the key constituencies, parents groups, treatment, the lawyers side of the house, the cops, everybody. Then we came up with strategies. These were true collaborative strategies where people bought in as real stakeholders, where they had a feeling of ownership and were then able to go out and implement strategies. And had ONDCP done that, which they haven't—this administration and ONDCP has never done. They don't hold key constituent meetings. We have never had focused groups and constituent meetings to develop the National Drug Control Strategy or this strategy or the Southwest Border Strategy.

The newly emerging Fentanyl threat is being driven by the HIDTA directors in the Chicago and Philadelphia police departments, not by ONDCP as it should. And let me add by saying that ONDCP—I was cornered in the hallway, and they were outraged at my testimony, my written statement, because I affirmed that they had not been collaborative. They said, well, we sent an e-mail to the HIDTA directors. And I said, you know what? An e-mail, without knowing what you are working on or where it is coming from, a simple one e-mail traffic is not a collaborative process. When we sit down with all of the stakeholders, the people on this panel and all of the groups that they represent, that would be a collaborative process. That would have been a strategy that we and you could buy into. But they didn't do it.

Mr. SOUDER. Any other comments on that?

Mr. COLEMAN. Yes, I do. We think what ONDCP did was put the cart before the horse. They should have had the meth summits prior to listen to what was coming out of them. Now, the counties are to be involved with the summits in which we look at the regional plan and all of that coming at the national plan and which will be addressing this problem. But to come out with all these plans without the stakeholders being involved doesn't help, doesn't solve the problem; it only creates a problem. And then when you don't put the money with it, it also creates additional problems. So we are looking forward to the summits. We will be involved in that, and we will come up with a national plan.

Mr. SOUDER. It is pretty massive when you look at all the different narcotics and you look at all the different challenges in the regional variations. But one of the things is—with meth—that is so unusual is that we could see it coming. And that is what is so exasperating here, is now we are kind of maybe at least at a flattening if not a decline in the mom-and-pop labs. But I remember years ago, the Asians in our international narcotics legislators—anti-nar-

cotics legislators groups raising synthetic drugs. And the Europeans and the South Americans and the North Americans going, well, we don't even know really what you're particularly talking about at this point. But in Hawaii, they did. So they have a long track record in Hawaii. And then it hits our West Coast, and it just marches. And in a hearing in Minnesota, I asked if it had been in any of the Native American areas, and they said, it is devastating them, and yet that had never come up as a subcategory that—what I heard from the U.S. attorney who works with the northern U.S. Indian nations that it had become a bigger problem than alcohol. That is a pretty extraordinary statement for the government not to be aggressive and saying this isn't a national problem if it is in the Indian nations. And then there was this mythology that developed that somehow—I literally heard this at two different hearings out of the Federal Government, more speculative as to why this was in rural areas and not urban areas, that somehow African-Americans wouldn't be attracted to meth. And then in one in Minneapolis, the police chief there I believe said that in one neighborhood the particular distribution groups switched over, and all of a sudden, 20 percent of the cases in that city were African-American because one neighborhood switched over from crack and to crystal meth. And it appeared to be more of a distribution question. Well, that is a pretty fundamental misunderstanding in the Federal Government, to not understand the distribution patterns of how meth goes.

And I am just—Dr. Gallant, I saw you were going to add something here, too, in these conferences. But I am wondering whether, what kind of early warning system do we have for future things when—we talked about Chicago, Philadelphia. Some of these things pop up, and you can get them down quick enough. But this one was like a train that's been rolling for over a decade.

Mr. GALLANT. In terms of early warning, I think one of the things that our Federal partners, particularly SAMHSA, can do is to put into place early warning systems that are current. Many of the early warning systems they have currently are dated. You know, they go back 20, 30 years and really haven't caught up with what we are facing today. So a national strategy to get data, current data, usable data rather than just collect data based on some mythology from the past or some issue from the past that currently doesn't exist I think needs to be addressed.

Mr. SOUDER. For drug treatment and health questions, wouldn't we—much of the surveys I see and so often are like 3 years old. They will be 2001, 2002, 2003, and you're in 2006 trying to make legislative funding priorities. And that is helpful because that data will be more comprehensive, plus we have trend lines on some of that. But why wouldn't that in a logical way be supplemented with almost, in the days of Internet, instantaneous data on emergency room, drug court, which are two frontline groups.

Another would be, what we are picking up on the border on a daily basis. In other words, it is not like we are not accounting for this when the Department of Homeland Security picks this up if our suppositions are correct in that after certain States in the southwest start in that pseudoephedrine law, we should have seen if crystal meth's coming into the United States, and in fact, 60 to

70 to 80 percent of meth is crystal meth, and if it is coming across the southwest border and if we are actually intercepting anything, which is debatable, but if we are intercepting things, we should have seen a bump up, and it should have been almost instantaneous data that when a policeman makes an arrest on the street, that data gets fed into EPIC. It is like, why can't you have kind of an ongoing kind of daily tracking, which presumably some drug intelligence centers and EPIC do, but it doesn't seem to get to us? What we tend to get in our hearings are historical data. Any comments on whether you see more contemporary things than we see here?

Mr. BROOKS. Well, I think, again, the issue is a great example. As Fentanyl began to hit, as there was a seizure of Fentanyl coming across the border in San Diego, the San Diego HIDTA, the CBAG issued the first bulletin. It went out to law enforcement and ONDCP. We started to see Fentanyl deaths first in Chicago and then in Philadelphia and then in the Midwest, in the Kansas City area. And bulletins began coming out, and it was those emergency medical personnel and law enforcement and treatment folks in those cities that began to collaborate. So I think things do happen regionally. NDIC has just come out with an excellent Fentanyl bulletin out to law enforcement that is addressing the threat, and this is a breaking emerging trend. So things do happen. But there is disconnect, and it is really a shame, I think, that ONDCP is not the coordinator of pushing out this data, because they can get it out to all the constituent groups, to all the prevention folks, to the community coalitions, the law enforcement. But there is a disconnect there.

Mr. SOUDER. Do you get information as to, why Chicago and Philadelphia?

Mr. BROOKS. You know what, we are only surmising that there are some distribution groups that had the ability—that were in place there that had the ability to bring this Fentanyl from labs in Mexico. We believe anecdotally that the labs are in Mexico. Now, we have seen domestic labs in this country, Fentanyl labs. We struggled with a tough Fentanyl problem in California in the mid 1980's. I personally raided two labs back in those days. But we believe now it is coming out of Mexico. These tend to be controlled by drug, DTOs and families, and so it is probably just where they ended up.

Now, it's interesting, we just had three overdoses of Fentanyl in a California prison; one death, two recovered. So somehow the Fentanyl made its way into that prison. But we have not seen Fentanyl on the street in California yet. But I could tell you that, every single day, the HIDTA directors are communicating by e-mail not only with ourselves but with all of the law enforcement partners that we represent every day as this Fentanyl crisis is emerging.

Mr. SOUDER. I want to ask you a couple of questions leading to one broad one. But on the community anti-drug coalitions, do you get—how many are there? There are well over 100 now.

Ms. THAU. Nationwide, there are about—drug-free communities funded, are like 1,000. We have about 5,000 members.

Mr. SOUDER. You have 5,000 members; 1,000 are funded now through ONDCP. Now, in that thousand, do you get access to this kind of information of what is happening regionally?

Ms. THAU. We get access to them as far as what is going on in their coalitions. We actually collect the data, which is how we came up with the outcomes to put in this package.

Mr. SOUDER. Like if Fentanyl all of a sudden pops up in two markets, you would see your data collection pop up?

Ms. THAU. They would be, because they have police and law enforcement—every single one of these coalitions has law enforcement sitting there for exactly that reason; because if you are going to comprehensively look at what you are doing in a community, you have to talk to your emergency room people, you have to have police at the table. And the school survey data may be every 2 years, but the point I was going to make is the stuff that you hear from the Federal Government is monitoring the future, which is a survey sample nationally, which masks all of the richness of what is happening in regions and specific communities in the country. And that's probably why they haven't seen it, because they are not looking at what communities and States are looking at, which is their data. And as you know, the data issue is that a lot of these Federal agencies like Safe and Drug-Free Schools don't even ask for the data from the States and the States have it. The States that have had big meth issues have seen, as we said, higher usage rates among their students than States that didn't have a big meth issue.

So the States and the communities get it, but it is never aggregated up to the point that it comes to you, other than these national samples that mask all of the variation in local and regional data.

Mr. SOUDER. In the community anti-drug initiative, you are not limited just to youth?

Ms. THAU. No.

Mr. SOUDER. One of the things that came up in the National Ad Campaign is we addressed meth, and in your testimony, you showed kind of the introductory process of alcohol, tobacco, marijuana, cocaine, and how the process ages. Our National Ad Campaign is geared toward youth. The theory was—is that, if we tackle, kind of break—at the current time, it is marijuana. Everything else will be controlled.

How do we do a post-analysis to say that strategy failed? In other words, that it is hard to say how much it failed because, in fact, marijuana use was going down, yet a methamphetamine epidemic would hit a community and wipe it out regardless of whether the kids have gone to Safe and Drug-Free Schools and had the other things or not, and yet our ad campaign was just focused on below 18. We suddenly have a problem that is devastating our local task forces. Our hospitals, everything, drug courts everything else are overwhelmed when it hit a market, and yet we say, well, we addressed this back when they were 16. Do you have any thoughts on whether or not our policy in many areas in prevention—Drug-Free Schools would be one example. International youth ad campaign doesn't really tackle the richness of the assumption.

I have asked these questions for years because I have a theory that the reason we went to youth campaigns was not just to prevent at an early age. It is because it is easier to get kids to agree than it is to get adults to agree. And that it was the ease of having kids go, yes, I think drugs are terrible. And then we move it down farther because—and yet the tough ages are junior high and into high school, and it gets even tougher when you are dealing with somebody on an assembly line. A woman is trying to lose weight, and they want to use methamphetamines. They don't necessarily remember back in fifth grade. How do we—any thoughts on this subject? And, for example, why weren't the community anti-drug coalition systems oriented toward youth? If this whole thing could be solved if we addressed youth, you obviously when you worked with the development of this program wanted to go beyond youth.

Ms. THAU. Well, ONDCP is focused on youth. However, it is community-wide. And what we know is that drug trends do start in using populations, but then they go down. Like ecstasy started in older populations and ended up in high school kids.

Part of the issue is what you said before about, how do you do a strategy? One, do you need basic prevention for everybody? Yes. Do you need then to hit specifically specific drugs within that? You do. You can do the base prevention, but if we know that risk—perception of risk and social disapproval for specific drugs is what drives the trends on those, you can't just think that general drug prevention is going to totally do it. You have to build into it components for the emerging drug trends as they are coming up. And you have to be very cognizant of what age groups are using what substances.

Mr. SOUDER. Any other thoughts on this? I wanted to touch on one other point with treatment and Dr. Gallant. And we have heard multiple witnesses and including in my opening statement say that a mythology developed that meth—there wasn't really a good treatment for meth. Part of the way this mythology developed, quite frankly, because sometimes we hold up the grassroots as all knowing. It came from the grassroots. Because I have conducted at least 10 hearings on meth, and I have had at least 5 hearings where treatment experts testified at regional level that meth was different in treatment, that it was hard to treat, unsolvable to treat; that local places—this was not some kind of mythology developed in Congress. This was a mythology that developed at the grassroots. Are you telling me that meth can be treated like any other drug? That it is harder, easier to treat? It is like what? Because it is important if we are going to clarify the record here to try to figure out how to clarify the record.

Mr. GALLANT. We do believe that meth can be treated like any other drug. But one of the distinct differences in meth is duration of treatment. And I think as, Congresswoman Watson pointed out, when she went to the one program that she felt might have some value for her niece, it was a long-term program of up to 24 months individualized for the person entering in the program. So the feature we found with the meth is that it is such a powerful drug; it is such an addictive drug, that in order to get the person clean and sober and into recovery, it takes much longer than for some of the other drugs that our system encounters.

Mr. SOUDER. I believe it was in your testimony that you listed some of these drug programs that had the—

Mr. GALLANT. Yes. Colorado, Tennessee.

Mr. SOUDER. I think one of them said in Utah, if I remember—Utah that 60.8 percent of methamphetamine users were abstaining at the point of discharge. Which means that 40 percent were still using meth at discharge?

Mr. GALLANT. True. At some level.

Mr. SOUDER. Is that indicative more of what you were saying about the length of time that they may have had short programs or that they—because you—discharge, could discharge in that case also mean that they were expelled from the program or withdrew from the program? It is not completion of a program.

Mr. GALLANT. Right.

The CHAIRMAN. So that helps me understand that figure because it is a wide range. Some had—where you have 80 percent after 6 months, that is a different standard than—but would the word discharge, which you used in your testimony in a number of places, does discharge usually mean that the person—would that include withdrawal? And when you say—so let me—I am trying to sort out the data here, because you kind of had apples and oranges mixed here, and I am just trying to compare them.

If Utah had a 60 percent in their State division who are abstinent at time of discharge, that would mean everybody who entered the program, including those who withdrew, failed, were kicked out, maybe it was voluntary people who left. Then if you say, in Tennessee, that 65 percent were abstinent 6 months after treatment, that wouldn't necessarily—those would be probably people who completed the program, and then 65 percent. Because it wouldn't—do you know of any surveys that surveyed the people that dropped out in trying to measure whether people are impacted afterwards? It is usually if they've completed the program when they do the measurement.

Mr. GALLANT. The data that we presented probably would not include those who dropped out and did not have a positive outcome.

Mr. SOUDER. And in the data that you presented, I know these are difficult questions because there are, in the prepared testimony, a few examples, and didn't examine all the subcomponents of that. But would this data that you had for Colorado, Idaho—and the written testimony, Colorado, Iowa, Minnesota, Tennessee, Texas, Utah, which ranges from the kind of the extremes of only 60 percent in effect being abstinent, who went in, and statewide in all treatment, to 80-some percent being abstinent at discharge, which is a 60, 80, Colorado, Utah, to 73 percent 6 months after in Minnesota? Is that comparable to the range of type of things we would see if this survey had been cocaine?

Mr. GALLANT. Probably. What we are trying to demonstrate there is that treatment is effective, and it is effective long range. At discharge, the person was clean. Six months later, we went back and interviewed the person again to try to determine if they had reverted to use. The data suggests that they had not reverted to use, that they were clean 6 months post-discharge from the program as a success.

Mr. SOUDER. As we move toward our treatment hearing, one of the questions that—because I am sure at least somebody from your association will be involved in that, if not you directly. Could you look and see how this data that you have been collecting on meth, how that compares to other drugs? And if it is substantially different, meaning substantial variation, minimum 5 percent—10 percent would be pretty significant—if it is by 10 percent different, I mean actual 10 percent range, that would be more like 15 percent actual over the top, if it is significantly different—because we know there is going to be differences, because we—where it is newer and some States were farther along, some States were more rural than urban, what they pay their treatment people. I understand all the variations. That is why a normal statistical difference might be five. I am looking for a lot more than five. If there are statistical differences in meth effectiveness from cocaine, heroin, marijuana, other drugs. Then, second, whether that gap has closed in the last few years because SAMHSA has been looking at doing more directed meth treatment.

And then, if there is a gap and it is not closing, is part of what I suggested earlier part of this problem that rural treatment facilities do not—where many of the meth addicts are—are not there? And in fact, it isn't a treatment question; it is that the longer-term, higher professional, more expensive treatment is not available in the areas where the meth is?

Because if, in fact, it is the same, then my premise, that there was a difference in rural health care from urban health care, wouldn't really be there. In other words, if in fact you are finding right now that meth treatment is just as effective as cocaine treatment, then we don't really need to look at whether we need special programs in rural meth treatment, because in fact it is working as well as everything else. If there is a gap, then we need to figure out whether we need to do something particularly for meth. And that is going to be one of the main focuses of our hearing, what unique challenges are there. Because if the data is good, that is where you go. Look, you don't need to customize everything strategy if there are certain basic principles that work, if length of time is a major variable, if it is training of the individual.

Now, we have had a lot of testimony particularly from grassroots providers that meth seizes the body differently in that it has a different impact on the brain. Do you agree with that?

Mr. GALLANT. I would agree with that.

Mr. SOUDER. And so that is why the treatment would be longer?

Mr. GALLANT. Well, again, I think that the addictive properties of meth are such that it just sort of wraps the person up. In order to get the person clean takes a longer length of stay than you might find with other drugs.

But to answer your other question about rural versus urban, one of the things we know we have to attend to, if we are not, is work force development and provider development. You know, we can get all the money in the world, but if you don't have a competent work force to deliver the service regardless of wherever they are, you are not going to achieve your objective. So our goal as an association is to ensure that we work with SAMHSA and HHS to ensure that we have a good solid provider development program, a good solid

work force development program. They have two mechanisms in place currently that allows them to get to that. One is the Addiction Technology Transfer Services, and the other is the centers for the application of prevention technologies. They are underfunded. I think ATTSS are funded at about \$11 million. That is not a good work force strategy. You can't adequately cover the country with a work force strategy involving \$11 million. So our goal is to look at getting a more competent work force in place, having a variety of mechanisms to do that; you know, not only through conferences but basic education, community colleges, secondary; you know, universities, graduate school programs, to help those who want to enter this field get into it and get the skill sets they need to be competent in their work. And then for providers. Providers sometimes get into this business thinking that they want to do good but don't have the ability to run a business. So we need to help them understand how you run a business, how you access funding, how you write a grant, how you hire people, and how you manage a facility. Those are basic tenets of trying to run a good business. And that is one thing that our system currently does not pay a lot of attention to.

Mr. SOUDER. Let me finish with a series of questions around this subject, because having worked with this for a long time, it has really reared its head in the meth question, and that is that, how do you deal with the different intensity of impacts of some drugs versus other drugs? And even within that drug, a disproportionate impact from one type of that drug versus the other? So let me give you—let me relate this particularly.

Part of the reason that the politics of this are different—and it isn't the politics just at the Federal level. There is no question that the most important significant thing in moving us to a national meth strategy was the National Association of County Survey. And we can never thank you enough. Because by nationalizing it through your county organizations and surveying them and having them respond, which if there is ever a doubt that, at a local level, that a survey like this or the input works, this one did, because we constantly heard it was a regional question. It is a regional question. Yeah, but you know what? If you add up every region, it's a national question. The only place it wasn't there really was New England, and now we are learning that Florida has much more of a problem than they thought they had, and they supposedly in the southeast didn't have much. But as it is rolling around, we found out, well, they did, they just weren't paying as much of it—it wasn't as big a focus. Because part of the difference here was the mom-and-pop labs so devastated our drug infrastructure that the impact of the narcotic became—you know, we would have a regional hearing. And I could see the crowd get restless every time DEA said the basic same testimony: That two-thirds, which is now they say 80 percent, is crystal meth. And the local community would get all restless. First off, they wouldn't necessarily see the crystal meth as much. But the mom-and-pop, the Nazi lab type things would tie up your local drug force so that you couldn't even find out whether you had crystal meth. You couldn't find out whether you had crack. You couldn't find out whether you had marijuana because your drug task force in one of my counties was

sitting there 6, 8 hours at a house. So they couldn't pick up anybody else. And so it had a disproportionate impact on the ability of our drug task forces to work. That, we would go into a community in—Ramsey County is one that sticks out, but I know Lee Terry told me similar things happened in Omaha. We heard similar testimony in Oregon, that when meth would hit a community in the mom-and-pop labs, which would tend to be picked up first because local law enforcement can't let these idiots explode the buildings in their towns, blow up kids in the house and so on, get ammonia and everything else into the water in the community, so that obviously had to be a takedown. So they would take down those first. So the emergency room admissions were more likely to be mom-and-pop lab people tying up the emergency rooms because that is who the law enforcement were having to deal with because, like in my area, they catch a building on fire and whatever.

California was the first State that really had this devastating—which led to their law. Now, that disproportionate impact we heard in Ramsey County. Then the next thing is that they went from a standing start to, 6 months, 80 percent of the kids in child custody were meth users, from zero to 80 percent in 6 months, which meant that the child custody program was overwhelmed, because when you have some idiot cooker in their home with little kids present, you can't leave the little kids in there that—so they are going to wind up in child custody. So all of a sudden, kids who are in child abuse homes, conventional child abuse, don't have a place to go because 80 percent of your people are being taken up with urgent meth cases; that we heard in drug courts, in different cities, drug courts would go from 10 or 20 percent to all of a sudden 80 percent. In Elkhart County in my district, the county, the jail went from nothing to 90 percent being meth users, which meant that you couldn't—you can talk all you want about marijuana laws, but you can't arrest anybody for marijuana if your jail is full. You don't have any place to put them. I mean, you can give them a ticket or something, but you don't have any place to put them. You don't have any place to put people who stole a car because your jail is full of meth users.

Now my question is, do we have an adequate way in our system to measure in our targeting that if something kind of rips the guts out of the system, what is the point of us funding a diverse drug task force if one drug is wiping out the task forces? If it is hitting the emergency rooms? If it is hitting the drug courts? And part of the political frustration here is the politicians understood that. Because if you're a county commissioner, you have to figure out how to pay for it; that the police, the narcotics officers were on to this because they were standing at a house waiting forever for DEA or EPA to come over, to get there. And yet the political system was saying, well, it's only 4 percent; who gives a rip if it's 4 percent? It's wiping out your budget.

How do you suggest that we kind of incorporate into our national drug strategies intensity? Because that is really what we are talking about here. And that is why, should there be a measure that emergency that I just gave you, a series of variables that potentially could do that. But that seems to be some of what we are fencing around here, is because when they unveiled the meth raids and

they came to the meth caucus and told the meth caucus: That problem's kind of under control; it is declining and so on. And it is, like, where? It's certainly, even in my district, they will say it is declining. Now, instead of being 30 percent over budget on overtime, they are 10 percent over budget on overtime. Instead of having 60 labs, they have 40 labs. Instead of not being able to get to all the meth people, they are now able to get to maybe 60 percent of it. But still in Allen County, my home, which had very little, and in multiple other counties, we are getting—and this comes to the treatment question—that—well, in Noble County, that the prosecutor said he had one guy, he was up the third time and he still hadn't been sentenced by the judge for the first time.

Now, this is what's driving the locals crazy. And when anybody who watches this saying, well, meth seems to be getting under control, it is not measuring the intensity of the impact that it is having on the child support system, on the local law enforcement system, on the jail capacity. And even if this declines 15 percent, 15 percent doesn't alleviate the pressure, unless the 15 percent—or 25 percent, I guess it was for mom-and-pop labs. I am not sure 25 percent alleviates the pressure. It may be that we have to go 50 percent on the mom-and-pop labs. Because if there is not an intensity measure here, it is just some kind of number we picked out of the sky. And I want to get your reaction to that. I know you basically agree with that. But as you go into these conferences, one of the questions is, how do you pick up intensity? Fentanyl is an example. I mean, all of a sudden, a whole bunch of deaths. That is as many deaths from one drug that nobody ever heard of than you have in a city with all the other drugs combined for that same period. How do you measure intensity, and how do we factor that into our planning?

Mr. GALLANT. Well, I think one way we can do it is to work with SAMHSA and HHS to develop a national data system to collect data regarding use, intensity of use, and so forth. Right now, the block grant moneys that come to States we do provide client level data, but that is the only Federal money that comes to States that require client level data. So you have a whole other set of dollars coming out of the Justice Department, coming out of other agencies that don't collect or don't provide the single State authority data that they then can roll up to SAMHSA to give a national picture of use.

So one of the recommendations I would have is that anyone receiving Federal dollars should be required to link with the SSA, to ensure that SSA is collecting client level data so we can get a whole picture of what is going on nationally regarding use.

The other piece that I think would be good is to have data flow up. And the National Household Data Survey, I think as pointed out by Sue Thau, really—doesn't really give you sub-state level indications of use. It gives you a national picture, but it doesn't allow you to say what is going on in the bowels of—how or what's going on in the counties of Indiana or the cities of Indiana. That can only be done by developing a system that allows States to take a real good snapshot of what's going on within their areas, and then feed that data up to our Federal partners to get a national picture.

Mr. SOUDER. Because in Indiana, for example, I think we were fifth in labs, but really less than 20 percent of the State is impacted by meth labs. In my own district, I have three of the major counties, and then I have two counties that don't have a single one, basically, or minimal even in the same geographical area, and one county is next to another county. One county had I think 80, and the other county had zero labs, and they are both rural counties next to each other. That, trying to understand the intensity of the panic and how to deal with this is one of our huge challenges. Mr. Coleman.

Mr. COLEMAN. We agree with your statements, Mr. Chairman. We don't have the answers and the numbers that you are looking for, but we would be willing to work with you. We do know one thing: It is affecting county budgets across this country untold. The amount of cases being heard in the drug courts is phenomenal. From 1 year to the next, it seems to be doubling and tripling. Yet we are all looking for these answers, and we hope that, by working together as a collective group, we can come up with these answers and start addressing this problem immediately, not in 2011.

Mr. SOUDER. And it's a challenge that isn't just meth. I was trying to address it as we look in the overall drug strategy, because, as you well know, that in the early 1980's, crack is still a huge—and cocaine—is still the biggest problem in my biggest city, Fort Wayne, which is not that far from Detroit. And there was at one point where we were very high in the number of crack houses, and crack was devastating the city of Fort Wayne. And literally, the way we learned what was leading to this huge growth of gangs was in the course of a—the prosecutor and my then boss Congressman Coats, we put together a thing where one of the things the prosecutor initiated was giving a urine test to the kids at the youth center. Found that almost all of them were tested for crack. And it's like, crack. That was up in Detroit; that is not down in Fort Wayne, which then, when they start to go through some of the gang kids, realized that there was a connection to some of the groups that were coming down. And at one point, there were 155 crack houses in the city of Fort Wayne. Now, that doesn't mean 155 working on a given night. What it means is there were 155 houses where they were moving through that were abandoned in the urban area, which then often led to a reaction: Well, you tear all that down, and then you have all these vacancies, and then people wonder why you can't get a grocery store to work in a community. And we have watched in our urban areas kind of this reaction and over-reaction to how you deal with those kind of drugs. Because when an intensity grabs a community, whether it is meth or whether it is cocaine or whether it is Fentanyl, it has a disproportionate reaction. And unless we are reacting to some degree to the topic at hand, we are not relevant. And then we can't get by into the overall narcotics strategy, because people go, well, why are you doing that when I have this problem here? Because ultimately you do have to have some threat of a national strategy that is common with all this. You can't go jerk into whatever the drug is of the day. But if you don't have any responsiveness, local law enforcement goes: What are you doing? This isn't my problem.

Any other comments on this on how you might address it?

Mr. BROOKS. Well, I don't know exactly how to address it, but you have hit the nail on the head. There are really two meth problems in America. There are the small toxic labs which are really the face of meth. I mean, when communities think of meth, they think of all of the medical and law enforcement and child protective services that are tied up with drug-endangered children, with environmental issues, with law enforcement issues. But DEA and DOJ is probably correct: 80 percent of our meth probably is from large drug trafficking organizations, super labs in California, and now increasingly more in Mexico. And these are poly drug issues. I mean, when we buy meth in California, traditionally they will say, OK, you want 50 pounds of meth, but you have to take 3 pounds of heroin and 10 kilos of coke, because we are a poly—you know, because that's their business plan.

So we can't lose sight of one problem for the other. And that is traditionally what it seems like we do, is we chase our tail a little bit and we run around. We have to be more flexible. And I think part of being more flexible and responsive—and that is my frustration in this Synthetic Drug Control Strategy, is the fact that nobody talked to the treatment docs, to the cops, to the community anti-drug coalitions, to the trial protective services workers. Because if you talk to them, you will have a pretty good picture of what is going on in America. You will understand pretty much how we need to craft the strategy. And so if we stay—if we keep that in sight—and I think Congressman Cummings made the point earlier in his comments, that we have to talk to the people that are on the ground doing the job, and be able to respond immediately, as we are responding to Fentanyl, as we responded to meth in the early days in 1995 and 1996 as it became an emerging problem when DEA ramped up.

You mentioned the tribal lands issue, and I have to give credit to the U.S. DOJ, especially the Bureau of Justice Assistance. They are ramping up training for tribal lands' meth issues. They have ramped up on the National Criminal Intelligence Sharing Plan, on the risk projects that help us share all this information and work smarter. They are working on an incentive program that helps train us and let us work smarter. DEA is doing an outstanding job. The Office of State and Local Affairs at ONDCP is working diligently with the HIDTAs to do a good job, and the disconnect appears to be at the leadership from ONDCP.

Mr. SOUDER. Any other comments?

Ms. GREEN. Mr. Chairman, one of the things that would help, and it relates to everything we are saying, is to have an infrastructure. And, again, this is not my forte. But in terms of the work that we do with all of our colleagues, it would help to have an infrastructure that could actually pull information on a number of different variables, meth lab seizures, foster care placements, county budgets, treatment admissions, community coalition information, and people who are qualified at a national level to review all of that information and hopefully assess what that means in terms of intensities on the other impacts.

Some of the things that we ran into earlier on when we were working on the meth issue is that some people would only focus on usage numbers and completely ignore the massive drain on system

resources that were occurring in a number of the States. So rather than get into those particular fights involving resources, it would have been helpful to have someone who was actually pulling all this information and saying, well, look what's happening with treatment admissions, look what's happening on county budgets, look at lab seizures, look what's happening in schools. We never had that. And so we ended up with individuals, at least in our work at State and local levels, fighting over, well, usage numbers are really this. And yet we had Ron and his colleagues and Sue and her colleagues and Eric and his colleagues and Dr. Gallant, his colleagues saying: Well, yes, but we're having a—we're feeling a significant impact on this.

So it would be helpful to have that kind of infrastructure, not just on meth. Because if the infrastructure is set up properly, then it can respond quickly. Part of the frustration for all of us on the meth is that without that kind of infrastructure there was a lot of crisis management going. When we were working with States on State legislation, mostly people were not coming to us in a preventive mode with the exception of the last year. They were coming to us in a crisis mode, saying, we've got 1,400 labs, we've got to do something.

If there had been a proper infrastructure in place to do the kind of early warning that you are suggesting, somebody would have known in advance, wait, a minute, it's impacting law enforcement, foster care placements, county budgets, treatment admissions, communities, and schools. None of us had that information available to us. We didn't have anybody saying that to us. It was because we decided to coordinate with each other and said: Well, what are you seeing? What are you seeing? What are you seeing? What are you seeing? That is how we figured it out. And one of the frustrations for us is that early on when we were trying to work with State and local legislatures, part of it was, who is just looking at usage numbers saying, you know, really this isn't a problem is ONDCP.

Mr. SOUDER. I thank you all for your comments. One of the things that—I mean, because, ultimately, this is what ONDCP is supposed to be doing. And the question is, why aren't they? Is it structural, or is it individual, or is it both? To the degree it is structural, we passed our House version; the Senate is moving it. But as we move to conference, maybe we can look at, is there a way to build in a structural way to get the kind of input into the ONDCP reauthorization. Individuals change; the structure outlasts the individuals. And we need to look at how we need to work some of these big questions through as we are working the HIDTAs, as we are working the community anti-drug coalitions. But then, part of it is that we've got things in multiple agencies: DOJ; Safe and Drug Free Schools is over in education; treatments in HHS. And how—that was why we created a drug czar's office, was to try to at least influence and coordinate the information as these things are in multiple agencies. It has been pretty frustrating to me that the Department of Justice clearly has been involved in meth longer and at the grassroots, and yet Members of Congress basically—and I don't know how many hearings I had, it was like, why wouldn't the administration just come out and say that they were involved?

It was like pulling teeth. And I think part of it is that I'm not even sure the Department of Justice was aware at the grassroots how involved their local DEA agents were in the task forces, how involved their—what exactly was being done with their grants. They were anti-drug grants. And then in the communities, when they started dealing with it, it was meth. And the information was just seeping back to Washington that they were up to their eyeballs in meth, and they didn't know it. But what it meant was we didn't have any cohesion to trying to address what was overwhelming at the grassroots. And I think your input here has been helpful. We appreciate that. We will have this continuing dialog. We have a couple more field hearings coming up yet this summer. And thank you once again.

Does anybody have any closing comment you would like to make? Then, with that, the subcommittee stands adjourned.

[Whereupon, at 12:09 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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August 12, 2005

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BERNARD SANDERS, VERMONT,
INDEPENDENT

Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

It has been my understanding, from several sources, that the Department of Health and Human Services has been the principal barrier preventing the Administration from formulating a policy to address the methamphetamine epidemic. And now I have learned that the Department of Health and Human Services is a *primary sponsor* of a conference controlled by the Harm Reduction Coalition and the Harm Reduction Project in your home state of Utah, on August 19 and 20, 2005.¹

I find this all to be deeply offensive.

I am enormously frustrated with your Department for dithering on the meth issue while the rest of America fights an epidemic that is viciously tearing apart families and communities throughout the country.

A foundational premise of the so-called "harm reduction" ideology promoted at the HHS-sponsored conference is that we should not be fighting a "war on drugs," but rather limiting drugs' harmful effects. Harm reduction is, in fact, a vehicle drug legalization proponents have hijacked to pave the way to their ultimate objective.

Any claim that your Department is unaware of the pro-legalization agenda and "soft" approach to illegal narcotics of the harm reduction advocates is utterly implausible. This agenda is readily apparent from the conference topics sprinkled throughout the program, as well as the very websites of the assorted harm reduction organizations sponsoring and participating in the conference.

Shockingly, Major Session IV of the HHS-sponsored Harm Reduction Coalition and Harm Reduction Project conference next week is entitled, "We Don't Need a 'War' on Methamphetamine."²

¹ See <http://harmredux.org/sponsors.html> (last visited August 11, 2005).

² See <http://www.harmredux.org/ConferenceProgram2005NEW.pdf> (last visited August 11, 2005).

Other conference topics include, “You Don’t Have to Be Clean & Sober. Or Even Want to Be!” and sexual topics consistent with the harm reduction ideology that shuns an abstinence-based approach for at-risk communities: “Tweaking Tips for Party Boys,” and two sessions on engaging in sex without condoms, “Barebacking: A Harm Reduction Approach,” and “Without Condoms: Harm Reduction, Unprotected Sex, Gay Men and Barebacking.”³

Among the speakers and moderators at this conference sponsored by your Department, five are identified in the program as representatives of the Drug Policy Alliance, giving seven presentations at the conference. The Drug Policy Alliance describes itself as “the nation’s leading organization working to end the war on drugs.”⁴ Along with its major donor George Soros, the Drug Policy Alliance helped produce *It’s Just a Plant*, a pro-marijuana children’s book.⁵ Marsha Rosenbaum, who is also presenting at the HHS-sponsored conference,⁶ wrote the epilogue for this disturbing book.

Both the Harm Reduction Coalition and the Harm Reduction Project are partners with the Drug Policy Alliance for its upcoming 2005 International Drug Policy Reform Conference. According to the Alliance’s conference materials regarding who should attend this meeting: “Anyone who believes the war on drugs is doing more harm than good!”⁷

The program for the HHS-sponsored conference next week also includes a “Special Thank You” to a handful of people, including HHS employee Dr. Glen Hanson, of the National Institute on Drug Abuse (NIDA). As you know, NIDA’s mission is “to lead the Nation in bringing the power of science to bear on drug abuse and addiction.” To what end is the Department’s goal to “lead the nation” with harm reduction and drug legalization partners?

Luciano Colonna, Executive Director of the Harm Reduction Project and host of the DHHS-sponsored conference, and one reported as briefing your aides in advance of the conference,⁸ is quoted as stating that, “For a lot of people, meth use is a rite of passage and it really does increase sexual pleasure.”⁹

³ Id.

⁴ See the Drug Policy Alliance website at <http://www.drugpolicy.org/homepage.cfm> (last visited August 12, 2005).

⁵ Cortes, Ricardo. *It’s Just a Plant*. Brooklyn, NY: Magic Propaganda Mills Books. January 2005, 48 pages. The book is also promoted on the Drug Policy Alliance website at

<http://www.drugpolicy.org/library/bookstore/ijap1104.cfm> (last visited August 12, 2005).

⁶ Ms. Rosenbaum is presenting “Safety First: A Reality-Based Approach to Teens, Drugs and Drug Education.”

⁷ See <http://www.drugpolicy.org/events/dpa2005/> (last visited August 12, 2005).

⁸ Stewart, K., “‘Significant meth problem’ in Utah” *The Salt Lake Tribune*, August 10, 2005, p. A7.

⁹ Shell, B., “Meth conference to focus on ‘comprehensive care’ Organizers want to explore mix of drug, unsafe sex, HIV” *The Washington Blade*, August 12, 2005 (available at <http://www.washblade.com/2005/8-12/news/national/meth.cfm> (last visited August 12, 2005))

That Administration officials from your Department are consulting with harm reduction advocates such as Colonna, and sponsoring conferences controlled by the harm reduction network, completely undermines the work of the President, the Congress, and the men and women who work in law enforcement across the nation who are trying desperately to fight the meth epidemic.

Please provide the following materials no later than 5:00pm Tuesday, August 16, 2005:

- 1) An official statement of why the Department of Health and Human Services is sponsoring the August 19-20 Harm Reduction conference in Salt Lake City, and how such participation furthers the Administration's stated goal of reducing drug use.
- 2) The names of all Department of Health and Human Services staff attending the August 19-20 Harm Reduction conference in Salt Lake City, and their contact information so we may conduct staff interviews.

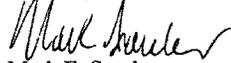
Please provide the following materials no later than 5:00pm Friday, August 26, 2005:

- 1) All documents relating to the Department of Health and Human Services' involvement, including its role as a primary sponsor, for the August 19-20 Harm Reduction conference in Salt Lake City. See the attachment for a full definition of "documents" and "relating to."

Mr. Secretary, I have steadily worked for enhanced treatment and prevention funding and expanded treatment options. I was the House sponsor of the Drug Addiction Treatment Expansion Act just signed by President Bush.¹⁰ Treatment and prevention are not the issue here.

The issue is that the Administration has not yet put forth a strategy to address the meth epidemic, and your Department bears much of the responsibility for that failure. To procrastinate further while supporting the very people who advocate relaxed drug laws is unconscionable.

Sincerely,



Mark E. Souder

Chairman

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

Attachment: Definitions

¹⁰ Pub. L. 109-56 (August 2, 2005).

ATTACHMENT

1. The term "documents" is to be construed in the broadest sense and shall mean any written or graphic material, however produced or reproduced, of any kind or description, consisting of the original and any non-identical copy (whether different from the original because of notes made on or attached to such copy or otherwise) and drafts and both sides thereof, whether printed or recorded electronically or magnetically or stored in any type of data bank, including, but not limited to, the following: correspondence, memoranda, records, summaries of personal conversations or interviews, minutes or records of meetings or conferences, opinions or reports of consultants, projections, statistical statements, drafts, contracts, agreements, purchase orders, invoices, confirmations, telegraphs, telexes, agendas, books, notes, pamphlets, periodicals, reports, studies, evaluations, opinions, logs, diaries, desk calendars, appointment books, tape recordings, video recordings, e-mails, voice mails, computer tapes, or other computer stored matter, magnetic tapes, microfilm, microfiche, punch cards, all other records kept by electronic, photographic, or mechanical means, charts, photographs, notebooks, drawings, plans, inter-office communications, intra-office and intra-departmental communications, transcripts, checks and canceled checks, bank statements, ledgers, books, records or statements of accounts, and papers and things similar to any of the foregoing, however denominated.
2. The terms "related to" or "relating to" means anything that constitutes, contains, embodies, identifies, deals with, or is in any manner whatsoever pertinent to that subject, including but not limited to records concerning the preparation of other records.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 17 2005

The Honorable Mark Souder
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
House of Representatives
1227 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Souder:

This is in response to your August 12, 2005 request relating to a Conference on Methamphetamine, HIV and Hepatitis. Thank you for bringing this important issue to my attention.

In fact, the Department of Health and Human Services (HHS) is not a sponsor of the conference you referenced. Conference organizers incorrectly listed HHS as a sponsor of the event without the Department's knowledge or consent. Conference organizers were mistaken and are removing the Department's name as a sponsor.

Six employees from CDC will be participating in the conference. Participation by CDC employees at conference sessions and exhibit booths will convey critical messages about reducing methamphetamine use and the infectious diseases associated with methamphetamine use. It will also enable CDC representatives to continue to learn how methamphetamine use is impacting communities in the US and what efforts may be working to reduce methamphetamine use. If you would like to discuss these matters with employees who attend the conference, the Department will make arrangements for such a meeting.

I'm disappointed that you apparently received incorrect information relating to your assertion that HHS has been a barrier towards the formulation of an Administration policy. In fact, the Administration is taking a strong approach to the methamphetamine problem, including efforts toward prevention, treatment, and education. The Department has partnered with the Department of Justice and the Office of National Drug Control Policy, as well as state and local officials, to combat the methamphetamine threat.

In combating the methamphetamine challenge, HHS believes a balanced approach emphasizing prevention, treatment, and supply reduction has been demonstrably effective at reducing public health threat of drug abuse. To that end, HHS is undertaking a number of steps. These include:

- 1) **Access to Recovery** – A new consumer-driven voucher program that provides grants to states for treatment and recovery.
- 2) **Substance Abuse Prevention and Treatment Block Grant** – Through this block grant, HHS provides \$1.8 billion annually for state substance abuse prevention and treatment programs to address methamphetamine abuse and all other substance abuse treatment needs.
- 3) **Strategic Prevention Framework** – HHS has awarded Strategic Prevention Framework grants to 24 states and 2 territories to advance community-based programs for substance abuse prevention.
- 4) **Drug-Free Communities** – This HHS administered program supports approximately 775 community anti-drug coalitions across the country.
- 5) **Research Into Medications and Behavioral Therapies** – Funding of methamphetamine-related research has increased almost 150% from approximately \$15 million in FY 2000 to more than \$37 million in FY 2004. The National Institute of Drug Abuse (NIDA) is tracking use of methamphetamine; supporting research into medications that may reduce or eliminate cognitive impairment and treat overdoses; and research into the most effective behavioral therapies for methamphetamine addiction.
- 6) **Assistance On Meth-Related Child Abuse** – The Administration for Children and Families (ACF) has established a National Resource Center on Child Protective Services to provide technical assistance to state and local Child Protective Services agencies to improve their prevention, assessment and treatment of child abuse and neglect.
- 7) **Targeted Capacity Expansion Grants (TCE)** – Later this week HHS is announcing \$16 million over three years for 11 new SAMHSA TCE grants focusing on treatment for methamphetamine addiction. TCE grants help States and local officials identify and address new and emerging trends in substance abuse treatment needs.

These are a few of the steps HHS is taking to fight the problem of methamphetamine. I hope this is helpful to you.

Sincerely,


Michael O. Leavitt

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INDEPENDENT

August 19, 2005

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Your August 17, 2005 response to my letter regarding the sponsorship by the Department of Health and Human Services (HHS) of this week's Harm Reduction Coalition/Harm Reduction Project "methamphetamine" conference in Salt Lake City, Utah, simply does not answer the questions I asked. In fact, it raises many more serious questions.

First, and most importantly, I am incredulous that, even as you insist that HHS is not "sponsoring" the conference, you admit that HHS provided taxpayer dollars for it, and that you are sending six employees to participate in it. I would like to learn how it is that you differentiate between providing financing and employees for an event, and "sponsoring" it.

In fact, I am inclined to agree with one of the event's primary organizers, Mr. Luciano Colonna, who told a reporter, "They [HHS] were a sponsor and still are sponsors. If they weren't sponsors, why didn't they just say that nationally when attacked by Souder last week?"¹ I further note that, as of Friday, August 19, 2005 at 9:00 AM, the first day of the conference, your Department's name remains on the conference program.²

Your Department's support for, and participation in, this conference has already served to confer undeserved legitimacy on the drug legalization proponents who organized it. HHS participation and public sponsorship of the conference influenced the judgment of other government entities. For example, Oklahoma state agencies originally

¹ See Aaron Atwood, "Tax Money Goes to Conference Condoning Sex / Drug Use," CitizenLink, Aug. 17, 2005, <http://www.family.org/cforum/feature/a0037571.cfm>

² While the name HHS has been removed from the conference website, it remains on the final event program. You may view this program and the name of your department amongst the primary-sponsors at <http://www.harmredu.org/ConferenceProgram.pdf>.

planned to send officials to the conference in large part because of the federal government's sponsorship.³

Second, you did not respond to the second stated request of my letter asking for the names of all HHS staff attending the Harm Reduction Conference. This request stands and is reiterated at the end of this letter.

I am, moreover, bewildered by your assertion that six Centers for Disease Control (CDC) employees will attend the conference "to learn how to reduce methamphetamine use." This conference, as the organizers clearly state, concerns so-called "harm reduction", that is, drug use *maintenance*. That is quite different from drug use reduction.

I believe that your Department's participation in this conference is a slap in the face to the federal, state, and local law enforcement, child welfare services, treatment and prevention, and other personnel who work so hard to stop meth trafficking, abuse, and addiction, and to clean up the wreckage left by this terrible drug.

To give you a specific example, Danni Lentine, one of the CDC employees, will be moderating a panel discussion at the conference entitled, "Demythologizing Methamphetamine Manufacture: Don't Believe the Hype" on Saturday, August 20.⁴ The very title of this "discussion" suggests that the law enforcement and child welfare services personnel, who have provided moving testimony to my Subcommittee of the deadly health hazards posed to police officers and children at meth lab sites, are perpetrating a "myth". That, Mr. Secretary, is disturbing, particularly when the Administration has proposed drastic cutbacks in federal programs that help state and local law enforcement agencies find and deal with meth lab sites.

Yesterday, you joined Attorney General Alberto Gonzalez and Director John Walters of the Office of National Drug Control Policy, and announced your support for the Administration's anti-meth proposals. Your words, however, ring rather hollow when your Department is providing aid and support for the very people who undermine anti-meth policies.

I am attaching the same questions I put to you last week. I request that you provide the answers as soon as possible.

³ See Atwood, *op cit*.

⁴ This panel appears on page nine of the conference program. Both this page and a complete listing of presentations which appear to be important to your CDC employees is available on the internet <http://www.harmredux.org/ConferenceProgram.pdf>.

Thank you for your attention to this serious matter.

Sincerely,

A handwritten signature in black ink that reads "Mark Souder". The signature is written in a cursive style with a large, prominent "M" and "S".

Mark E. Souder
Chairman
Subcommittee on Criminal Justice,
Drug Policy and Human Resources

ATTACHMENT

- 1) An official statement of the Department of Health and Human Services position on needle exchange, drug legalization, the communication of infectious diseases during intercourse with or without the use of a condom, and whether "harm reduction" policy has reduced drug use.
- 2) The names of all Department of Health and Human Services staff attending the August 19-20 Harm Reduction conference in Salt Lake City, and their contact information so we may conduct staff interviews.
- 3) The names of all Department of Health and Human Services staff attending the following conferences:
 - a. HIV/AIDS Conference
Nov. 29 – Dec. 1, 2005
<http://www.purposedriven.com/en-US/Events/AIDS/Overview.htm>
 - b. The Church and the HIV/AIDS Pandemic
February 19, 2005
<http://www.hivaidsconference.com/home.cfm>
 - c. Prescription for Hope: The International Christian Conference on HIV/AIDS
February 2002
http://www.samaritanspurse.org/index.asp?section=Projects&page=PFH_03.txt
- 4) All documents relating to the Department of Health and Human Services' involvement, including its role as a primary sponsor, for the August 19-20 Harm Reduction conference in Salt Lake City. See the attachment for a full definition of "documents" and "relating to."

Definitions

1. The term "documents" is to be construed in the broadest sense and shall mean any written or graphic material, however produced or reproduced, of any kind or description, consisting of the original and any non-identical copy (whether different from the original because of notes made on or attached to such copy or otherwise) and drafts and both sides thereof, whether printed or recorded electronically or magnetically or stored in any type of data bank, including, but not limited to, the following: correspondence, memoranda, records, summaries of personal conversations or interviews, minutes or records of meetings or conferences, opinions or reports of consultants, projections, statistical statements, drafts, contracts, agreements, purchase orders, invoices, confirmations, telegraphs, telexes, agendas, books, notes, pamphlets, periodicals, reports, studies, evaluations, opinions, logs, diaries, desk calendars, appointment books, tape

recordings, video recordings, e-mails, voice mails, computer tapes, or other computer stored matter, magnetic tapes, microfilm, microfiche, punch cards, all other records kept by electronic, photographic, or mechanical means, charts, photographs, notebooks, drawings, plans, inter-office communications, intra-office and intra-departmental communications, transcripts, checks and canceled checks, bank statements, ledgers, books, records or statements of accounts, and papers and things similar to any of the foregoing, however denominated.

2. The terms "related to" or "relating to" means anything that constitutes, contains, embodies, identifies, deals with, or is in any manner whatsoever pertinent to that subject, including but not limited to records concerning the preparation of other records.



**National
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Executive Director
Sherry L. Green, Esq.

September 29, 2006

The Honorable Mark E. Souder
Chairman

The Honorable Elijah E. Cummings
Ranking Member

House of Representatives
Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources
2157 Rayburn House Office Building
Washington, DC 20515-6143
Majority: (202) 225-5074
Minority: (202) 225-5051
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Dear Chairman Souder and Ranking Member Cummings:

Greetings from the National Alliance for Model State Drug Laws (NAMSDL)! Thank you for the opportunity to appear before you and the Subcommittee on Criminal Justice, Drug Policy and Human Resources on June 16, 2006 during the hearing "Evaluating the Synthetic Drug Control Strategy." The following pages offer my response to the questions for the record related to this hearing that you requested. If you need additional information or clarifications, please feel free to contact me.

Thank you again for including NAMSDL in this hearing. If we can be of further assistance to you, other members, and your staff, please let me know.

Sincerely,



Sherry L. Green, Esq.
Executive Director

The National Alliance for Model State Drug Laws (NAMSDL) is a resource for governors, state legislators, attorneys general, drug and alcohol professionals, community leaders, the recovering community, and others striving for comprehensive and effective state drug and alcohol laws, policies, and programs.

Funded by Congressional appropriations since fiscal year 1995, NAMSDL is a 501(c)(3) nonprofit, bi-partisan organization. NAMSDL is the successor of the President's Commission on Model State Drug Laws.

1. States have taken the lead in passing legislation to address restricting access to the precursor chemicals of methamphetamine. As stated in your testimony, “Based on states’ success with these legislative efforts absent Administration support, it is unclear from the strategy how its future involvement may be relevant.”
 - a. The extensive efforts of 35 states in enacting laws restricting the availability of precursor chemicals, not to mention the passage of similar federal legislation, has already led a decline in small toxic labs (STLs) of approximately 26.4 percent between 2004 and 2005, as highlighted by the Strategy in the Continuing Progress: A Status Report. In light of this strong trend, how ambitious is the Administration’s goal of reducing domestic STLs by 25 percent over three years?

During 2005 and to date in 2006, forty-two states have adopted measures to establish or enhance existing controls on access to over-the-counter (OTC) pseudoephedrine products. Examples of STL declines cited by individual states after implementing restrictions include an 80% reduction in Iowa (June – December 2004 compared to June – December 2005), a 79% reduction in Oregon (June 2004 – October 2004 compared to June 2005 – June 2006), and 66% reduction in Oklahoma (January – December 2004 compared to January 2005 – December 2005). States in which the restrictions have been in place long enough to have STL reports assessed describe similar levels of decline. Therefore, much of the “heavy lifting” in reducing domestic STLs has already been done by states. It is reasonable to expect that the momentum created by the steep declines will continue to result in further decreases in STLs over the next three years. However, the rate of decline may occur at a more gradual pace than in previous years *or* the numbers of STLs may level off.

The Administration’s success in reducing STLs by 25% over three years may be directly tied to its success in helping states address the demand for methamphetamine. Significant declines in STLs have not brought about a similar decline in the use of or addiction to methamphetamine. In a conversation with me in late 2005, the late Lonnie Wright, Director of the Oklahoma Bureau of Narcotics indicated that most of the remaining labs that his staff was finding were “repeat customers” – individuals producing meth not for profit but for their own use. Director Wright indicated that OK would not arrest its way out of these remaining labs – addiction treatment was needed for these individuals. Additionally, the Iowa Office of Drug Control Policy reports that demand for meth has remained unchanged during the same period on which the above-mentioned 80% reduction in labs was reported.

With the decline in domestic STLs, the demand for methamphetamine fueled by addiction is being increasingly supplied by importation of methamphetamine. If officials are able to significantly reduce the importation of methamphetamine, there may again be pressure to meet demand through the manufacture of the drug within the U.S., using new and different production methods to circumvent the current OTC restrictions. As meth “cooks” moved from ephedrine to pseudoephedrine, then bulk supply to OTC supply, domestic producers may again adjust to implemented controls. Therefore, the significant reduction of domestic labs over the long-term depends in part on the strength of the Administration’s efforts to address methamphetamine addiction through appropriate and adequate prevention and treatment initiatives.

Another factor that may make the Administration’s goal of reducing domestic STLs difficult to achieve is the continuing decline of resources for state and local law enforcement. As both Chairman Souder and Ranking Member Cummings noted in the June 16th hearing, the Administration again proposed to eliminate the Byrne/JAG funding. While Congress is likely to restore dollars for this program in the final iteration of the fiscal year 2007 federal budget, states have experienced reductions in this funding the past two years. Based on NAMSDL’s contact with state and local law enforcement officials, my understanding is that drug enforcement task forces are often the efforts hardest hit by these reductions. Couple these reduced resources with an increase in imported/trafficked meth into the states, state and local law enforcement may not have the “staff power” to find and address even a diminished number of STLs.

Given the significant reductions in labs already achieved by states and the above-stated factors that may complicate further declines, states' input toward the Administration's goal of reducing domestic STLs by 25 % over three years would have been imperative toward ensuring a realistic goal. It is my sincere hope that this input was solicited and incorporated into the stated goal.

- b. Please explain the statement in your testimony that these legislative measures were enacted without "the benefit of ONDCP officials testifying to the national priority on meth-related problems -as they have on other substance abuse issues in the states"?**

It is well documented that ONDCP has provided testimony, op-eds, and other assistance to states as part of efforts to defeat legislative initiatives related to medical marijuana and decriminalizing marijuana. Additionally, ONDCP has supported states efforts to pass enabling legislation to establish prescription monitoring programs (PMPs) by providing testimony at hearings, making informational calls to legislators and key stakeholders in states, and highlighting these programs in the National Drug Control Strategy. However, to NAMSDDL's knowledge based on our work with states to address methamphetamine issues, ONDCP did not similarly support states' legislative efforts to restrict pseudoephedrine products. Further, NAMSDDL's understanding is that it was as recently as his appearance at the Midwestern Governors' Association Meth Summit in December 2005 that Director Walters publicly acknowledged that meth was a significant national problem and applauded the efforts of states. By this point in time, 35 states had already passed or were close to passing new or enhanced OTC restrictions.

- 2. Your testimony highlights that "the Strategy does not include specific proactive steps to provide State and local policymakers with accurate information about existing options for the treatment of methamphetamine addiction."**

- a. Besides the regional methamphetamine conferences, does the Strategy include any specific proactive steps to be taken by federal agencies with regard to implementing the Strategy?**

Because NAMSDDL's area of work with states is domestic legislation and policy, I have insufficient information to assess the relevance of the international, supply reduction initiatives detailed in the Synthetic Drug Strategy.

Regarding domestic issues, the Strategy was a response in part to individuals who expressed concerns over the last several years about the Administration's lack of a comprehensive, coordinated plan to address methamphetamine problems. Those who strongly recommended that the Administration develop a plan included state and local officials, drug and alcohol professionals and members of Congress. Given that the Strategy was born from a reactive state of mind, it can be difficult to identify steps in the Strategy that are proactive in the leadership sense.

Despite this, there are some specific action items outlined in the Strategy that, if properly implemented, would assist states and bring about an objective identified in the Strategy. On page 37 of the Strategy, the Administration commits to a plan to expand and improve the knowledge base regarding the proper environmental response to meth labs based on the best scientific research available.

The Strategy proceeds to outline specific steps (p. 39-40) that the Environmental Protection Agency (EPA), in coordination with the Drug Enforcement Administration (DEA), will implement as part of the plan. This includes discussion of the release in six months of a research strategy, including specific topics to be included, to support federal health-based guidelines for remediating meth labs. The Strategy further commits the Administration (p. 38) to the development and publication by January 2008 of guidelines that identify the best practices for the remediation of former meth labs sites.

State and local practitioners, including those in the 13 states that have adopted specific decontamination standards for former meth labs sites, have long requested that the federal government conduct the necessary remediation research and develop, with the input from the state and local levels, related health-based guidelines.

The Strategy also identifies (p. 41) the Administration's objective of helping child victims of methamphetamine. It identifies certain activities on drug endangered children issues (DEC) which the U.S. Department of Justice (DOJ), National Institute on Drug Abuse (NIDA), and other agencies will undertake. Most notably, these specific activities include establishment of DEC protocols, sharing of best practices, provision of DEC training for tribal authorities, and studies to better understand the consequences of methamphetamine exposure. These activities, if properly implemented, would help child victims by assisting states to provide increased and improved medical and social services to young people found at or near methamphetamine labs.

3. How significant is the current "gap between federal action and states' needs? Does the Strategy include initiatives that will make progress to close this gap?"

The current gaps between federal action and states' needs are significant. The divergence has often led to the perception by state and local officials that drug control strategies emanating from the federal government are federal, not national, strategies. Federal action intended to assist states often fails to keep pace with the nature of states' problems the action is designed to help address. Rather than functioning as an early response system to help states tackle immediate issues and prevent new or additional problems, federal action often becomes a delayed response mechanism. Federal action to address an expressed need of states is, at times, announced after the scope of that need has already changed due to states' adoption of more timely responses. Moreover, federal action to assist states is often crafted without the meaningful and practical input from the state and local levels.

Consequently, the gaps are largely products of focus and resource allocations. With regard to focus, an example of a resulting gap is the Strategy's focus on the 18-month study of the effectiveness of states' restrictions on pseudoephedrine products at a time when 42 states have implemented some measure controlling these products and are now more focused on legislative, policy and programmatic priorities related to prevention, treatment, and cleanup/remediation issues. As noted by members during the June 16th hearing, the Strategy's discussion of treatment and prevention initiatives is underwhelming. On the funding, the Strategy repeatedly discussed the leadership and partnership with the states, particularly among law enforcement, that are needed yet the Administration has offered back-to-back budget proposals that would cut funds to states that support the very efforts described in the Strategy. This is a significant disconnect.

As noted previously, the research on remediation of meth labs and related development of health-based remediation standards *could* help states establish or enhance procedures to properly clean up meth lab sites. Additionally, the proposed DEC projects *could* help states provide more and better services to children exposed to methamphetamine lab sites.

Whether these initiatives, promising as they sound, **will** assist states depends on the Administration's ability to translate the words in the Strategy into appropriate, practical action. This translation can only be effectively accomplished by obtaining the meaningful input and participation of state and local officials and drug and alcohol professionals.

The Administration – ONDCP in particular as the coordinating entity – states in the Strategy its intention to "strengthen its partnerships with State and local officials" (p. 19). If – led by ONDCP – the Administration follows through on this intent in such a way that state and local input is constantly considered and incorporated into federal initiatives and strategies, this could begin to close the gap between federal action and states' needs that currently exists in alcohol and other drug efforts. The Strategy, however, does not include detail as to how this might happen. Strategies such as the one put forward on synthetic drugs cannot continue to be "top down" to states and expect to effectively address the needs experienced at the state and local levels.



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Executive Director
Lewis B. Gallant, Ph.D.

September 29, 2006

The Honorable Mark Souder, Chairman
Subcommittee on Criminal Justice, Drug
Policy and Human Resources
Committee on Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and our subsidiary organizations, the National Prevention Network (NPN), and National Treatment Network (NTN), thank you very much for inviting me to testify on June 16, 2006 before the Subcommittee on Criminal Justice, Drug Policy and Human Resources regarding the Office of National Drug Control Policy's (ONDCP) Synthetic Drug Control Strategy. We appreciate the opportunity to provide input.

Recently, you submitted a list of questions to better help the Subcommittee understand significant issues related to the Synthetic Drug Control Strategy. Below you will find the questions, and corresponding answers, for your review.

Question: Did ONDCP consult with NASADAD on the treatment portion of the Synthetic Drug Strategy?

Answer: No, ONDCP did not consult with NASADAD on the treatment portion of the Synthetic Drug Control Strategy.

Question: Your testimony discusses the elimination of DOJ programs that "provide critical resources that help support methamphetamine treatment."

What impact will the elimination of the Residential Substance Abuse Treatment (RSAT) and the Byrne Justice Assistance Grant (JAG) programs have on the allocation and improvement of methamphetamine treatment throughout the country?

Answer: The elimination of the RSAT and Byrne JAG programs would negatively impact each State's overall capacity to meet the needs associated with addiction in general – and methamphetamine in particular. For example, in FY 2006, RSAT received

approximately \$10 million that allotted the following amounts to this sample of States:

- Indiana – Approximately \$200,000
- Maryland – Approximately \$200,000
- California – Approximately \$1 million
- Illinois – Approximately \$300,000
- North Carolina – Approximately \$250,000
- Florida – Approximately \$525,000
- Texas – Approximately \$1 million
- New York – Approximately \$400,000

The Byrne JAG program was funded at \$416 million in FY 2005. This funding supports a variety of initiatives with important treatment components. For example, the Byrne JAG program supports methamphetamine action teams in a number of States that address the variety of issues requiring attention during methamphetamine lab busts. Overall, elimination of programs such as Byrne JAG and RSAT would place more pressure on our State treatment, prevention and recovery system that already can not meet the current need for addiction services. Moreover, this would result in the incarceration of more addicted offenders without the treatment needed to successfully re-enter the community.

Questions: Many Members of Congress have been very outspoken concerning the need to develop clinically appropriate treatment protocols for methamphetamine addiction based on the experience of best practices. At the same time, NASADAD "believes successful federal initiatives acknowledge that each State substance abuse system is unique and faces unique and distinctive challenges."

A. Does the Strategy set goals related specifically to the treatment of methamphetamine addiction?

Answer: The President's goals for drug use overall were set in 2002 and included a ten percent reduction in two years and 25 percent reduction in five years. The Synthetic Drug Strategy sets a goal of reducing methamphetamine use by fifteen percent over three years.

B. Do the goals of this Strategy relating to treatment include the development of clinically appropriate treatment protocols in a flexible manner in order to meet the available resources of each State?

Answer: The Strategy expresses support for additional research by the National Institute on Drug Abuse (NIDA) regarding methamphetamine treatment and prevention. NASADAD strongly supports the work of NIDA. We also believe strong investments in NIDA should be made in order to enable NIDA to continue its work with States and others to improve practice and our understanding of methamphetamine itself.

I would also like to comment on the premise of your question, where you note, "Members of Congress have been very outspoken concerning the need to develop clinically appropriate

treatment protocols for methamphetamine addiction based on the experience of best practices.” You also highlight a quote from my testimony, when I said “... successful federal initiatives acknowledge that each State substance abuse system is unique and faces unique and distinctive challenges.”

NASADAD agrees that we must constantly strive to improve client care and we support work, as mentioned above, to expand and improve treatment protocols. We do not view my testimony as incongruent with the desire of Congress to ensure that clients receive the best care possible. We are aware of a number of best practices for treatment. NASADAD believes that new science and experience might improve them.

Similarly, States face different challenges related to methamphetamine. For example, Ohio experienced a total of 399 admissions for methamphetamine in 2004. In contrast, California saw close to 78,000 admissions for methamphetamine in 2004-2005. While both States are taking action to address methamphetamine, the specific needs of each State – and the service delivery systems themselves – differ greatly. This point is made in ONDCP’s Strategy, when it notes, “the manifestation of the synthetic drug problem in one State may be different from that in another State.”

C. Would coordination with Single State Authorities (SSAs) serve the development of treatment protocols based on best practices?

Answer: Yes, coordination with SSAs is vital and would help ensure that services are clinically appropriate. States and SSAs are working hard to develop and implement their own unique initiatives to continue to improve addiction services – including methamphetamine treatment. Virtually all innovations and evidence-based approaches in use today were developed in collaboration with State funded providers. Some State specific examples are below:

- *Arizona’s Bureau of Substance Abuse Treatment and Prevention* helped develop and establish the Arizona Methamphetamine Treatment Centers of Excellence. The Centers will examine key questions over time that include: Do clients served by the Centers demonstrate reductions in use along with improvements in other indicator areas (arrests, employment, etc)? How has the initiative impacted the organizational climate and culture of implementing agencies, perceptions and knowledge of staff regarding methamphetamine treatment? What are the best approaches for clients using methamphetamine?
- *California’s Department of Alcohol and Drug Programs*, which reported close to 78,000 admissions for methamphetamine in 2004-2005, is working closely with UCLA’s Integrated Substance Abuse Programs – one of the leaders in the country on methamphetamine research – to implement best practices and evidence based approaches to the problem. In addition, the Department is initiating the California Methamphetamine Initiative (CMI) which includes (1) a \$10 million methamphetamine public education campaign, (2) a methamphetamine practitioner’s reference guide to provide the most effective methods of treating methamphetamine, (3) competitive action grants to provide resources to local communities to

address local needs and (4) implementation of prevention initiatives stemming from the Governor's Prevention Advisory Council.

- *Indiana's Division of Behavioral Health and Professional Licensure* worked with the Department of Corrections (DOC) to develop a Memorandum of Understanding (MOU) related to methamphetamine recovery programs to ensure the promotion of best practices for treatment. In addition, the Indiana SSA has engaged in counselor training to help infuse the latest evidence based practices into the publicly funded system.
- *Illinois' Division of Alcoholism and Substance Abuse* sponsors training to providers on best practices in order to support improved retention and outcomes. In addition, methamphetamine has become a State priority, where the office of the Governor and Attorney General sponsor a task force on methamphetamine to increase public awareness.
- *New York's Office of Alcoholism and Substance Abuse Services (OASAS)* provides education and training to emergency services personnel, child protective services, social services, chemical dependence prevention and treatment providers, school personnel; established an Electronic Methamphetamine Clearinghouse; created and convened an Interagency Methamphetamine Steering Committee comprised of 12 separate State agencies to ensure a coordinated response to the problem of methamphetamine; and established an internal OASAS workgroup on methamphetamine.

These are only a few examples of State-specific initiatives that Governors and SSAs are moving forward in order to ensure clinically appropriate methamphetamine treatment, prevention and recovery services. In my testimony, I included additional State-by-State Snapshots on methamphetamine highlighting additional details.

At the national level, SSAs and NASADAD have worked diligently to ensure that State Directors are implementing effective treatment protocols. For example, SSAs and NASADAD have worked with NIDA, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Addiction Technology Transfer Centers (ATTCs) on a Science to Service initiative (and a Service to Science approach as well). This initiative promotes information sharing on the latest in research findings related to addiction – including methamphetamine treatment. As noted in the testimony, the mission of the ATTC network is to bridge the gap between alcohol and drug treatment scientists and substance abuse practitioners to help translate the latest science into actual practice. For the past three years, NIDA, CSAT and NASADAD co-sponsored a day long Science to Service symposium during the NASADAD Annual Meeting.

Question: The Strategy highlights the Drug Courts program, but at the current funding levels, will drug courts be able to have a national impact?

Answer: NASADAD believes that overall funding for the entire alcohol and other drug system benefits those with alcohol and other drug problems by helping expand capacity. Drug courts represent one aspect of the system. We recommend a strong link between the SSA and the Drug

Courts system in order to ensure clinically appropriate care and a more coordinated Statewide system of services. We also believe such coordination would help generate more consistent and helpful data. At current funding levels for all programs funded by States, counties, private payers and the federal government (SAMHSA, DOJ, etc), the data demonstrate that over 19 million Americans who could benefit from some level of treatment do not receive the services they need.

Question: Does the Strategy – or the Administration’s budget proposal – do enough to make sure that credible and essential treatment options are available for these drug courts to refer their participants to?

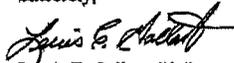
Answer: Again, our publicly funded substance abuse treatment, prevention and recovery system is currently overwhelmed due to lack of services to meet the demand. This problem with capacity is a common challenge among all NASADAD members. The critical ingredient for drug courts to be cost effective and successful is to provide the appropriate amount and duration of community based treatment. This need is often not sufficiently addressed in funding scenarios.

Question: The Substance Abuse Prevention and Treatment (SAPT) Block Grant, funded at approximately \$1.8 billion, is not even mentioned in the Strategy. Do you think these resources should have been incorporated into the Strategy?

Answer: We believe that any strategy relating to addiction treatment, prevention and recovery – including a strategy focusing on methamphetamine – should include a strong commitment to the SAPT Block Grant: the foundation of our publicly funded substance abuse system. The SAPT Block Grant is an effective and efficient program that is flexible in order to allow States to tailor their services and programs to fit local needs. SSAs and NASADAD are working in partnership with SAMHSA to implement the National Outcome Measures (NOMs) initiative. NASADAD supports NOMS and performance reporting. As noted by the National Governors Association (NGA), “The goal of this initiative is to improve service efficiency and effectiveness through the use of indicators of accountability and performance. The core principle driving this process is continuous quality improvement (CQI). In exchange for improved data, the federal government agreed to increase state flexibility in the use of...SAPT block grant funds and to reduce paperwork burden.”

Thank you again for providing me the opportunity to present testimony on behalf of NASADAD. I also appreciate the chance to offer you additional information to help clarify the testimony. Should you have any questions or require additional information, please do not hesitate to contact me or have your staff contact Robert Morrison, Director of Public Policy, at (202) 293-0090 x106.

Sincerely,



Lewis E. Gallant, Ph.D.
Executive Director

Cc: Dave Wanser, President

**Follow-up questions from Chairman Mark Souder
to the Department of Health and Human Services
following the June 16, 2006, hearing of
the Subcommittee on Criminal Justice, Drug Policy and Human Resources
Committee on Government Reform
entitled, "Evaluating the Synthetic Drug Control Strategy"**

QUESTION:

1. The Strategy speaks to the issue of drug courts, and we note that the President's budget does call for a substantial increase in funding. But a drug court can only be as effective as the treatment services its participants are referred to. Do you believe the Administration, through this Strategy, will be doing all it should be doing in the area of treatment?

ANSWER:

The Strategy highlights the work of the Department of Health and Human Services (HHS)'s Substance Abuse and Mental Health Services Administration (SAMHSA) in supporting programs for substance abuse treatment. SAMHSA supports treatment through competitive grants whereby public and non-profit private entities apply directly to SAMHSA for funds in areas chosen by the agency after consultation with stakeholders. Applications are reviewed and scored by experts from outside Federal government and SAMHSA funds those with the best scores.

One such competitive program is the Targeted Capacity Expansion (TCE) program under which SAMHSA continues to help States identify and address new and emerging trends in substance abuse treatment needs. In FY 2004, SAMHSA awarded funds to programs in California, Texas, Oregon, and Washington to provide treatment for persons addicted to methamphetamine. In FY 2005, SAMHSA awarded an additional 12 grants in New Mexico, Georgia, Tennessee, Oregon, Texas, Montana, South Dakota and California.

In his 2003 State of the Union Address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery (ATR), a new consumer-driven approach for obtaining treatment and sustaining recovery through a State-run voucher program. State interest in Access to Recovery was overwhelming. Sixty-six States, territories, and Tribal organizations applied and competed for \$99 million in grants in FY 2004. SAMHSA funded grants for three years to 14 States and one Tribal organization. Given the success of this program, and because the need for treatment is great, as methamphetamine abuse rates alone have demonstrated, the Administration is seeking \$98 million in FY 2007 to fund a new cohort of ATR grants, and \$25 million of that amount is specifically planned for a new methamphetamine treatment program.

Of the States that originally received ATR funding, Tennessee and Wyoming particularly focused on methamphetamine. The State of Tennessee is using ATR-funded vouchers to expand treatment services and recovery support services in the Appalachians and other rural areas of Tennessee for individuals who abuse or are addicted primarily to methamphetamine. Along with Tennessee, the Wyoming ATR program is also addressing the methamphetamine problem, focusing its efforts on Natrona County. This county has the second-highest treatment need in the

State and is considered to be at the center of the current methamphetamine epidemic in Wyoming.

SAMHSA funds substance abuse treatment activities primarily through the Substance Abuse Prevention and Treatment Block Grant. Appropriated at nearly \$1.8 billion in FY 2006, these funds are distributed to States using a formula dictated in statute. States have considerable flexibility in their use of the funds.

To help better serve people with substance use disorders, a true partnership has emerged between SAMHSA and HHS's National Institutes of Health (NIH) to more rapidly deliver research-based practices to the communities that provide services. SAMHSA is partnering with the pertinent NIH research Institutes – the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health – to advance a “Science to Service” cycle. Working both independently and collaboratively, these agencies are committed to establishing pathways to rapidly move research findings into community-based practice and to reducing the gap between the initial development and widespread implementation of new and effective treatments and services.

For example, SAMHSA began working on the problems resulting from methamphetamine in 1998 with a competitive grant program designed to expand on work done at NIDA on effective treatment for stimulants. SAMHSA's Center for Substance Abuse Treatment (CSAT) Methamphetamine Treatment Project (MTP) was the largest randomized clinical trial of treatments for methamphetamine dependence to date. Eight grants were funded in California, Hawaii and Montana. This effort helped identify proven ways of treating those dependent on methamphetamine.

Information on cognitive behavioral approaches to treat methamphetamine addiction are available in a set of two DVD's produced by SAMHSA's Pacific Southwest Addiction Technology Transfer Center and is discussed in SAMHSA's Treatment Improvement Protocol (TIP) #33 - Treatment for Stimulant Use Disorders. Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders and are part of the SAMHSA's effort in conjunction with NIH to bring science to service. TIPs draw on the experience and knowledge of clinicians, researchers, and administrative experts. They are distributed to a growing number of facilities and individuals across the country. TIP #33 describes basic knowledge about the nature and treatment of stimulant use disorders. More specifically, it reviews what is currently known about treating the medical, psychiatric, and substance abuse/dependence problems associated with the use of two high-profile stimulants: cocaine and methamphetamine.

Additionally, SAMHSA has been working in partnership with the Drug Enforcement Administration (DEA) to provide funding to support a series of Governors' Summits on Methamphetamine. These summits provide communities with opportunities for strategic planning and collaboration building to combat methamphetamine problems faced in their own communities. Summits have been held in 15 States. SAMHSA financed two conferences in spring 2006 on methamphetamine for States. SAMHSA brought in experts in the field of

methamphetamine treatment and research in a well received and much needed opportunity to learn and share information about methamphetamine.

QUESTION:

2. Though meth addiction is considered more difficult to treat than other chemical addictions, it's not a new drug, and professionals have been treating meth addicts for 30-some years.
 - a. What new methods of treating meth addiction are being researched, as noted in the Strategy?
 - b. Are any new theories of meth treatment really so promising as to justify further research spending, rather than shifting that spending in treatment for current addicts?

ANSWER:

Currently, the most effective treatments for meth addiction are behavioral therapies. However, researchers funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health within the Department of Health and Human Services (HHS), are pursuing the development and testing of new behavioral, pharmacological, and combined behavioral plus pharmacological treatments for meth abuse and addiction. New research findings about meth's actions in and effects on the brain are leading to innovative approaches in the development of medications to treat meth addiction. NIDA has increased its research budget that specifically targets methamphetamine by over 175 percent since FY 2000, to a FY 2006 level of \$41 million. The Institute continues its research on: levels and patterns of use; understanding how the drug affects the brain; its consequences for the brain and behavior; and developing effective treatments, both behavioral and pharmacological, for meth addiction. In addition, research that is relevant to methamphetamine problems is included in NIDA's broader portfolio on prevention, medications development, criminal justice, clinical trials, and HIV/AIDS.

For example, depression is often a complicating factor in recovery, and recent imaging studies show that during withdrawal the brains of meth addicts resemble those of depressed patients. Antidepressants may therefore help during these beginning stages of treatment. Recent study findings reveal that the antidepressant bupropion, marketed as Welbutrin®, reduced acute meth-induced subjective effects as well as cue-induced cravings. NIDA is currently conducting a clinical trial of bupropion for meth addiction.

Our knowledge of how addiction changes the parts of the brain that affect our ability to think, to control impulses, and to understand consequences, and how this disruption can predict treatment dropout and lead to continued abuse and relapse, is also leading to new targets for drug addiction treatment. We now understand that people undergoing addiction treatment also need medications to help them recover this functioning in order to give behavioral therapies the best chance to work. A "rising star" in this arena is modafinil, a medication which appears to improve cognitive functioning in people with schizophrenia and attention deficit hyperactivity disorder, which may also complement behavioral counseling for methamphetamine abuse. Meth exceeds other drugs in its disruption of cognition, especially attentional control, i.e., the ability to focus and ignore or inhibit distractions. Because modafinil has shown early efficacy in cocaine treatment and may have positive effects on executive function and impulsivity, it is being tested as a potential treatment in meth addiction.

New targets for medications development, such as these, hold great promise for treating meth addiction, and are thus highly worthy of further study.

QUESTION:

3. The Strategy notes that one of the most common methods of prescription drug abuse is sharing of drugs among family and friends. It then states that the plan for this problem “involves a closer partnership with the medical community, as well as a public education campaign.” No more details are offered.
- This promise could hardly be more vague and can’t credibly be called a strategy. Please explain the performance measures for a “closer partnership with the medical community.”
 - Please give us more details on this “public education campaign.” When does it begin? Who is in charge of it? How will it be funded? How will it be targeted? How will we know if it is succeeding or failing?

On this specific point, HHS will work with the Office of National Drug Control Policy (ONDCP) to alert the public and physician prescribers of opiates on the abuse potential and hazards of illicit use of opiates and offer strategies to secure opiate pain medications within households.

NIDA is also involved in physician’s outreach activities to better educate physicians about drug abuse. In 2004, NIDA began a Primary Care Physician Outreach Project, including representatives from the American Medical Association and more than a dozen experts in pediatric care, internal medicine, medical education, and board certification to develop recommendations for steps to increase awareness among primary care physicians and other medical professionals about drug abuse as a major public health issue.

NIDA has also been working with ONDCP to plan the Second Leadership Conference on Medical Education in Substance Abuse, scheduled for November 30-December 1, 2006, to continue the fruitful dialog with leaders in medical education, addiction medicine and addiction psychiatry begun in 2004. The goal of this Conference is to increase the knowledge of practicing physicians about the prevention, diagnosis, and early intervention in substance use disorders.

QUESTION:

4. Your prepared testimony for this hearing stated that in preparing the Strategy, HHS co-chaired with DoJ on foreign pseudoephedrine and with DEA on on-line diversion. Yet HHS has informed us previously that these are matters not involving HHS, and that are within the responsibility of DEA. At the hearing, you said you would have to get back to us on that. So what is your agency’s role?

ANSWER:

As we discussed with Subcommittee staff in a June 23, 2006, conference call, HHS was a member of the Synthetic Drugs Interagency Working Group (SDIWG), the group responsible for development of the Synthetic Drug Control Strategy (Strategy). ONDCP, the entity that chaired the SDIWG, created several subgroups to consider issues that were to be addressed in the Strategy, which was released in May 2006. For two of these subgroups, the Foreign Pseudoephedrine Subgroup and the Online Diversion Subgroup, ONDCP asked the Food and

Drug Administration (FDA) within HHS to co-chair the working groups. Both subgroups dealt with issues that FDA collaborates with the DEA to address. The Foreign Pseudoephedrine Subgroup considered recommendations on import quotas and import controls for pseudoephedrine. FDA was asked to co-chair this Subgroup since, in considering import quotas on any controlled substances and products subject to their jurisdiction, DEA works with FDA to obtain information to assess the medical need for the products and active pharmaceutical ingredients. Online diversion of these items is a topic of concern to the FDA, and since the problem of online diversion was discussed in the Strategy, FDA was given a role in the Online Diversion Subgroup's consideration of the topic. Other HHS agencies served on the Data and Research Subgroup, the State and Local Support Subgroup, and the Laboratory Remediation Subgroup.

Via email

September 15, 2006

The Honorable Mark E. Souder
Chairman
Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Souder,

Below are the answers to the follow up questions from the June 16, 2006 hearing that you requested I address in your letter dated August 11, 2006.

- 1. As the main point of reference for nearly every initiative and product of ONDCP, the Monitoring the Future study again is utilized as the primary measure within the *Continuing Progress: A Status Report* section of the Strategy.**
 - a. Your testimony states that many communities are seeing methamphetamine abuse statistics at levels far in excess of what the Monitoring the Future survey is measuring. Is this “special analysis” provided to ONDCP by Monitoring the Future a valid indicator of methamphetamine abuse amongst 8th, 10th, and 12th graders? If not, then why not?**

Monitoring the Future (MTF) is a valid indicator of national trends for alcohol, tobacco and drug use among 8th, 10th and 12th graders. MTF is an important tool for tracking overall and specific drug trends nationally. It is not, however, the appropriate tool for tracking a specific community's local drug use trends. As a representative national sample, MTF averages the high and low rates of drug use across various communities for all drugs of abuse, including methamphetamine. We know from NIDA's Community Epidemiology Work Group efforts that drug use patterns vary across regions of the country, as well as in specific communities within regions. MTF is, therefore, not an appropriate tool for communities to use in measuring their actual drug use patterns and trends. As a national sample, it does not accurately reflect what is actually occurring in a specific community. Although it is valid for ONDCP to use MTF as a national snapshot for tracking drug use trends, such as methamphetamine, over time, communities themselves must conduct their own local surveys to determine their actual local rates of drug use. MTF's national sample can mask the variations in drug use among specific communities for drugs such as methamphetamine.

2. The Strategy itself points out that states and cities must be organized to recognize and deal with methamphetamine. Yet it fails to mention, even as a resource, the Drug-Free Communities program, which has been very successful in identifying and addressing methamphetamine issues in communities where it has emerged as an issue.

a. Did ONDCP or any other department or agency from the Administration consult with CADCA on preparing the Strategy?

Neither ONDCP nor any other department or agency from the Administration consulted with CADCA on preparing the Strategy.

b. If the Administration wants to organize on the local level to deal with the methamphetamine issue, why does the Administration not even mention the Drug-Free Communities program, which operates on the local level?

CADCA has no idea why, if the Administration wants to organize on the local level to deal with methamphetamine, it neglected to even mention the Drug-Free Communities program in the Strategy. Coalitions should be an essential component in any comprehensive methamphetamine strategy because they are data driven, know their community epidemiology and are capable of understanding the multi-sector interventions required to reduce the availability and use of methamphetamine.

Communities with existing anti-drug coalitions can identify and combat methamphetamine problems quickly and before they attain crisis proportions. Methamphetamine is a multi-dimensional problem that demands comprehensive, coordinated solutions involving the collaboration of multiple community sectors that leverage community resources and major levels of citizen involvement. Coalitions throughout the country have effectively responded to the methamphetamine crisis and have seen reductions in its use.

3. The prevention section of the Strategy only mentions the National Youth Anti-Drug Media Campaign, the Strategic Prevention Network and student drug testing. Are these programs, standing alone and at currently proposed budget levels – adequate to meet the Strategy’s goal of reducing use by 15%?

CADCA does not believe that the National Youth Anti-Drug Media Campaign, the Strategic Prevention Framework State Incentive Grant program and student drug testing alone and at currently proposed budget levels, are adequate to meet the Strategy’s goal of reducing methamphetamine use by 15%.

While CADCA is supportive of the Media Campaign and applauds the fact that it has just launched a series of methamphetamine ads, this program, if not reinforced by other comprehensive school and community-based prevention efforts, will not be sufficient to prevent methamphetamine use by itself. Likewise, student drug

testing, if not built on a solid foundation of comprehensive prevention/intervention programming, is not capable of effectively preventing methamphetamine use by itself.

The one comprehensive program mentioned in the Strategy is the Strategic Prevention Framework State Incentive Grant program. Unfortunately, the President's FY 2007 budget request recommends reducing this program by approximately \$11 million.

The Strategy totally ignores two of the main federal programs that have been addressing methamphetamine: the Drug-Free Communities program and the State Grants portion of the Safe and Drug Free Schools and Communities program. These programs are vitally important because they fund community and school-based prevention infrastructures that can immediately incorporate methamphetamine components when this drug is identified as a problem.

Overall, the Strategy's focus on prevention is minimal in terms of both emphasis and funding and not at all adequate to achieve the goal of reducing use by 15%.

Should you have any additional questions, please feel free to contact me.

Sincerely,

A handwritten signature in black ink that reads "Sue R. Thau". The signature is written in a cursive, flowing style.

Sue R. Thau
Public Policy Consultant
Community Anti-Drug Coalitions of America

Hon. Mark Souder Questions for the Hearing Record
"Evaluating the Synthetic Drug Control Strategy"
June 16, 2006

Hon. Scott Burns
Deputy Director for State and Local Affairs
Office of National Drug Control Policy

1. The Strategy has set out three goals: a 15% reduction in meth abuse, a 15% reduction in prescription drug abuse, and a 25% reduction in domestic meth labs, all by 2008, with 2005 as the baseline. The Strategy says on page four that reported meth lab incidents in 2005 were down already by 26%.

a. Therefore, aren't the trends moving in this direction already? If so, could the Administration honestly claim credit two years from now for these reductions?

Yes, as to the first question: the trends are already moving in this direction, thanks primarily to new state laws that restricted retail access to products containing methamphetamine precursors like pseudoephedrine. Most states enacted these laws during calendar year 2005. The Strategy is a National strategy, not a Federal one; as such, the point isn't to try and take credit. Rather, the point is to work with state and local agencies to effectuate a reduction in methamphetamine laboratory incidents.

b. If the trends *are* moving in this direction, shouldn't you set your goals higher? What would be the point of setting goals that are going to be reached even if you do nothing?

As noted, 2005 is the baseline year for measuring this goal. However, the steepest decline in domestic methamphetamine laboratory incidents will probably have been from 2004 to 2005. If 2004 were the baseline year, this concern might be well-placed, but setting 2005 as the baseline year provides for an ambitious goal.

To be more specific: because most states implemented new restrictions in 2005, we expect that the greatest momentum in methamphetamine laboratory reductions will have been seen from 2004 to 2005 (from approximately 17,500 in 2004 to an estimated 12,700 in 2005). Although we expect that the momentum will continue, thanks both to state restrictions and the Combat Methamphetamine Epidemic Act (CMEA), the Administration recognizes that the reductions in 2006, 2007, and 2008 may not continue at the same pace as in 2005. The Administration believes that a 25% reduction over three years is appropriately aggressive. Restated in numerical terms, the baseline in 2005 is approximately 12,700 methamphetamine laboratory incidents, and for 2008, the Administration aims to see numbers drop to approximately 9,500 or fewer.

- 2. If ONDCP is going to wait until the end of the Bush Administration to announce whether the goals of the Strategy have been met, how are we supposed to hold anyone accountable before then? What kind of reporting can we expect from your agencies in the interim so that we can monitor the Strategy's progress?**

The Administration believes that it is important for a comprehensive strategy to commit to a course of action throughout the end of the President's second term. Because some data regarding 2008 will not be available until 2009 (after the President's second term ends), the Administration will submit an annual report to Congress and the American people in 2007 and 2008 as to progress toward achieving those goals, as well as a final report near the end of 2008.

- 3. Page six of the Strategy lays out seven trends that will be used to evaluate its success.**

- a. Will we have to wait until the end of 2008 for reports on these trends, or will we be given updates?**

As noted above, Congress and the American people will be provided with updates each year.

- b. Will ONDCP pick and choose among the data sets, or will it provide Congress with the full data? Will we see more "special analysis"?**

The data sets referenced in the Synthetics Strategy will be released when publicly available. Special analysis is requested when the normal data analysis process (for example, in the National Survey on Drug Use and Health) does not yield information which the Administration believes may be helpful in, for example, understanding an emerging threat.

- 4. Who will ultimately be responsible for making sure that all the relevant agencies are carrying out their assigned tasks under the Strategy?**

The Office of National Drug Control Policy (ONDCP), Department of Justice (DOJ) and Department of Health and Human Services (HHS) co-chair the Synthetic Drugs Interagency Working Group (SDIWG), which meets, on average, every two months to coordinate the implementation of the Synthetics Strategy. ONDCP is primarily responsible for ensuring that the SDIWG continues to coordinate these tasks.

- 5. Where do things stand now on getting the precursor-exporting countries to recognize the problem and assist in tracking and controlling exports?**

The Administration has communicated clearly to precursor producing nations, both bilaterally and multilaterally, that combating the diversion of methamphetamine precursor chemicals is a very high priority for our nation. We are working with the precursor-exporting countries in several ways. For example, the Director of National Drug Control Policy has met with government officials from each of the three producing countries discussing Methamphetamine abuse and precursor control. Officials included:

- The Chinese Head of the National Narcotic Control Commission
- The Chinese Ambassador to the United States, Zhou Wenzhong
- The Deputy Chief of Mission of the Indian Embassy
- The Deputy Chief of Mission to German Embassy, Peter Gottwald
- Ambassador R.S. Jassal and the Head of the European Union’s Delegation to the United States, John Bruton.

Additionally, earlier this summer, the Director signed a Memorandum of Intent with the Chinese head of the National Narcotic Control Commission for better cooperation on drug control issues. Moreover, the State Department is working with the U.S. Embassies in approximately 25 countries that import or export precursor chemicals to help prevent potential diversion of these substances and educate them on the new CMEA requirements concerning the largest importing and exporting countries of precursors. And the DEA, through Operation Prism, is working with the International Narcotics Control Board (INCB) to fully implement the Commission on Narcotic Drugs (CND) Resolution that was adopted in March of this year. The resolution provides for the stricter reporting and tracking of precursor chemicals by all countries. To date, DEA is pleased with the progress that the INCB has made implementing the resolution.

6. Who in the State Department – or any other agency – is responsible for following up ONDCP doing to make sure things are getting done?

The Department of State (DOS), specifically the International Narcotics and Law Enforcement Section, established an interagency working group to implement the international requirements of the CMEA. Active members of the group include DOJ, DEA, CNC, Office of the United States Trade Representative, Department of Commerce, HHS, and ONDCP. The members of this group, under State’s leadership, have worked closely to push the international community to properly control these precursors to avoid diversion. This effort includes proactive communication with both U.S. Embassy teams abroad and host nations.

7. The Strategy states that a key part of its international focus is to “continue to work closely” with Mexican law enforcement and “to strengthen border protection.” Yet the Strategy says nothing at all about how the latter will be accomplished.

Attacking the production and trafficking of methamphetamine from Mexican criminal groups has become a top priority of the United States Government and a topic that is addressed in every bilateral forum. DEA has worked with Mexican law enforcement on several initiatives focused directly on methamphetamine production and smuggling, and precursor diversion. ONDCP and DOS have worked very closely with the Mexican government to help strengthen their counterdrug efforts. Earlier this summer at the National Methamphetamine Chemical Initiative in Dallas, Texas, the Mexican Attorney General released Mexico’s nine-part strategy to combat methamphetamine production and smuggling, and precursor diversion. We believe that significant progress has already been made in reducing the licit import of pseudoephedrine and ephedrine into Mexico. The U.S. Government is working with the Government of Mexico to increase actions to combat the smuggling of precursors into Mexico from other countries, including African and Central American nations.

A. If the Administration is right in saying that 80% of the meth consumed in this country is coming from Mexican drug traffickers, then clearly the Strategy has to do more than state – without any elaboration – the we will “strengthen border protection.” So what is your agency going to do?

Over the last year, the administration has developed a comprehensive National Southwest Border (SWB) Counter-Narcotics Strategy that will strengthen border protection and addresses Mexican drug trafficking. The SWB Counter-Narcotics Implementation Plan is currently in the interagency clearance process and will be implemented soon.

B. Why was border protection not seriously addressed in the Strategy?

The SWB Counter-Narcotics Strategy and Implementation Plan is focused directly on this issue and the administration did not want to be duplicative in the Synthetic Drug Control Strategy.

8. The tone of the Strategy suggests that the administration understands the role of state and local authorities in combating synthetic drug abuse cannot be overstated. For example, it notes that over 90% of drug arrests and prosecution are carried out by state and local authorities. But for the Strategy to be successful, these people *must* be consulted first, in order that they might “buy-in” to the Strategy.

a. Please describe the steps you took to involve state and local experts in crafting this Strategy.

As noted in the first paragraph, second sentence of the Synthetics Strategy, the document itself is a companion document to the National Drug Control Strategy. Letters requesting input to the National Drug Control Strategy were sent to stakeholders around the country, including state and local authorities, faith-based and community organizations, and subject matter experts. ONDCP staff reviewed every response and took the input relating to meth and other synthetic drugs into separate consideration when drafting the Synthetics Strategy. In some cases, these letters were followed up with questions or further discussions.

Additionally, there were numerous consultations – in person, over the phone, and in the context of travel by ONDCP officials – in the months preceding the development and release of the Synthetic Drug Control Strategy. Senior ONDCP leadership, including Director John Walters and Deputy Director Scott Burns, traveled to dozens of different locations across the United States in the period of time during which the Synthetics Strategy was being developed (approximately nine months). Nearly without exception, these did not involve merely giving a speech, but discussing with, and listening to, state and local officials regarding methamphetamine and other synthetic drugs. Additionally, both Deputy Director Burns and his staff engaged in countless other communications, either over the telephone, in meetings, or by email, with state and local officials. And in mid-November, Associate Deputy Director John Horton sent an email to all HIDTA

Directors seeking their input for the Synthetic Strategy, and those of the law enforcement officials with whom they associated.

b. If the members of the second panel all say that there was too little consultation, why would they be mistaken?

ONDCP cannot speculate as to the basis for the second panel's witnesses' feelings or statements.

9. The Strategy touts the strong decline in domestic meth labs in the last two years, and it recognizes the role of state and local governments in achieving this. Yet we know that, in 2004 for example, a third of the meth labs seized were taken down by drug task forces that were funded through the Byrne Grant program.

a. How can the states keep up this pace of lab seizure if the Administration is successful in eliminating the Byrne Grants program?

A successful strategy to reduce methamphetamine production in the United States should focus on precursor control – to prevent the manufacturing before it occurs – as well as responding to the labs that are found. The Administration estimates that domestic methamphetamine laboratory incident seizures will have fallen approximately 29% percent (from about 17,500 in 2004 to about 12,700 in 2005) – nearly one third. This is primarily because of precursor control legislation and regulation at the state level. However, the Combat Methamphetamine Epidemic Act is designed to incorporate a similar standard nationally. With the estimated continued reduction in methamphetamine laboratory incident seizures, we expect a commensurate reduction in pressure upon state and local law enforcement budgets directly related to responding to, and “sitting on,” methamphetamine laboratories.

b. The Strategy states that the Administration sees its role in reducing meth labs as simply to provide reliable data to the states and to implement the Combat Meth Act. Does the Administration no longer recognize the vital role that Federal assistance – through programs such as Byrne Grants – provides to state and local anti-meth efforts?

This is a misreading of the Synthetic Drug Control Strategy. The paragraph referred to (on page 22 of the Synthetics Strategy) follows the section on state drug control strategies, and clearly begins by referring to state strategies on methamphetamine – the development, by state drug control officials, of a strategy to reduce or prevent methamphetamine production. In discussing what the Administration can do to assist states in the development of state-level strategies (emphasis added) to reduce the production of methamphetamine, the two roles referred to (reliable data, implementation of the Combat Meth Act) were identified. To suggest that the Synthetic Strategy declares that the Administration's only role in reducing methamphetamine labs involves those two

activities ignores pages 9 through 21, which detail issues involving international precursor control, law enforcement efforts, diplomatic efforts, border control and partnership with Mexican law enforcement and regulatory authorities – all with the objective of reducing methamphetamine production and supply.

10. The Strategy makes note of the “common misperception that methamphetamine addiction is so addictive that it is impossible to treat.” But the Strategy does not address what will be done to overcome this fallacy.

a. Has your agency mapped out a plan to fight this misperception? If not, why not? If you have, why was it not included in the Strategy?

ONDCP senior officials have spoken publicly, on numerous occasions, about the addictive nature of methamphetamine as well as the importance, and effectiveness, of support for treatment programs for all drugs including methamphetamine.

Dr. Bertha Madras, as Deputy Director for Demand Reduction, has boosted ongoing efforts by ONDCP to promote recovery options and overcome the misconception that meth cannot be treated. Dr. Madras was previously a professor at Harvard Medical School and is renowned for her research on drug use and the brain. Since she arrived at ONDCP, treatment has been one of her top priorities. She has met with Federal, State and local officials; community and faith-based organizations; physicians; treatment providers; scientists who investigate treatment methods; and subject-matter experts to discuss treatment, including treatment for methamphetamine. She has also traveled extensively to highlight treatment programs and provide assistance to communities facing drug problems such as methamphetamine; locations include Houston, Austin, San Antonio, Albuquerque, Phoenix, Seattle, San Diego, Los Angeles, Boise, Miami, Gainesville, Tallahassee, Philadelphia, Birmingham, Lexington, St. Louis, Chicago, New York City, and Hackettstown, NJ. She also has organized three video-conferences for 25 major cities on the necessity of screening and brief intervention to reduce drug use and attenuate progression to addiction.

On a recent trip to Los Angeles, Dr. Madras met with scientists and addiction specialists at UCLA to discuss the most recent evidence on methamphetamine consequences to brain and behavior, with the view of using this material for educating community and treatment providers with up-to-date prevention material. Significantly, she also met with treatment providers at a treatment center that developed the MATRIX model, a highly effective and widely used treatment protocol for methamphetamine addiction, in order to learn first-hand of their current methods, evidence for effectiveness, implementation, and dissemination. In Boise, Idaho, she visited a treatment center that focuses on methamphetamine and met with methamphetamine addicts to learn first-hand their experiences in treatment and recommendations on how to improve it.

ONDCP also works to ensure that Federal programs meet local needs, including the challenges communities face in regards to methamphetamine. Drug courts, student drug testing, screening and intervening, and Access to Recovery all provide resources for communities to meet these needs. For example, drug courts are an effective structure to intervene and heal meth users, and ONDCP continues to work with drug court professionals to promote proven practices for overcoming meth addiction. In Idaho, the majority of drug court attendees are meth addicts, and Dr. Madras met with drug court officials to discuss the issue. In Tennessee, drug courts have been touted by local officials as an effective way to target meth users, and ONDCP has highlighted their program as a model for other communities.

Access to Recovery (ATR) provides resources to grantee states to meet their unique treatment needs. ATR provides choice in treatment and recovery support services (RSS) to enhance outcomes. RSS is particularly relevant to those who suffer from meth addiction, since the drug can so disrupt their lives that additional services provided by ATR can make a substantial difference in accessing and successfully completing treatment.

ONDCP senior officials visit ATR programs routinely, and always make an effort to include providers, county health workers and others on the front lines of this problem so we can hear directly from them about the challenges they face. We also use visits as an opportunity to provide information on promising programs to heal methamphetamine users.

We urge Congress to fully fund these important programs.

b. What steps will you take to disseminate accurate information on prevention and treatment to policymakers and others on the state and local level?

Please see the above section on ONDCP's efforts to meet state and local officials in Washington, DC and in locations throughout the country.

11. The Strategy speaks to the issue of drug courts, and we note that the President's budget does call for a substantial increase in funding. But a drug court can only be as effective as the treatment services its participants are referred to. Do you believe the Administration, through the Strategy, will be doing all it should be doing in the area of treatment?

Yes. One of the Administration's top priorities with respect to drug treatment is to expand the range of services available to persons who could benefit from drug treatment. This is one of the reasons the Administration urges the Congress to support and fully fund the Access to Recovery program.

- 12. The Strategy notes that the Access to Recovery program is expanded in the President's 2007 budget. The House Appropriations committee has voted to eliminate it, so this won't help much if the Administration gives only rhetorical support. Does the Administration intend to fight for the ATR program?**

Yes. Administration officials, including ONDCP staff and leadership, have been vocal in urging the Congress to fully fund the Access to Recovery program.

- 13. The Strategy promises stronger support for the Drug-Endangered Children (DEC) program, which currently has reached 28 states. It says that we will expand DEC training to all 50 states by 2008, but it offers no details.**

- a. What do you mean by "all 50 states?" Does that mean one DEC team in each state?**
- b. How many DEC teams do we have to train before we know we are really meeting the need?**

Answering these questions together, the intent of this section is to ensure that training for at least one DEC team has occurred in each state, and in states with broader need, that the need is met. Each state is different in its need for DEC teams: for example, a smaller and more localized state with a smaller methamphetamine lab problem (such as Rhode Island) may have a different need than a larger state with a significant laboratory problem (such as California). ONDCP, together with DOJ, intends to work with state and local officials to ascertain continuing need and the effectiveness of the Administration in meeting that need.