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METH REVISITED: REVIEW OF STATE AND FEDERAL EFFORTS TO SOLVE THE DOMESTIC METHAMPHETAMINE PRODUCTION RESURGENCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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METH REVISITED: REVIEW OF STATE AND FEDERAL EFFORTS TO SOLVE THE DOMESTIC METHAMPHETAMINE PRODUCTION RESURGENCE

Tuesday, July 24, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:30 a.m., in Room 2203, Rayburn House Office Building, Hon. Trey Gowdy [chairman of the subcommittee] presiding.

Present: Representatives Gowdy, Mica, DesJarlais, Davis, Norton, Clay and Murphy.

Staff Present: Will L. Boyington, Staff Assistant; Molly Boyl, Parliamentarian; Linda Good, Chief Clerk; Mark D. Marin, Director of Oversight; Christine Martin, Counsel; John A. Zadrozny, Counsel; Jaron Bourke, Minority Director of Administration; Yvette Cravins, Minority Counsel; and Adam Koshkin, Minority Staff Assistant.

Mr. GOWDY. Good morning, welcome to everyone.

This is a hearing entitled, "Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence." The committee will come to order. I want to thank you all of our witnesses. I think we have two panels. I will recognize myself for purposes of making an opening statement and then the distinguished gentlemen from Illinois, Mr. Davis.

Again, I wanted to welcome our witnesses and thank them for lending us their expertise and perspective. I want to extend a personal greeting to my long-time friend, Max Dorsey, wherever he is. Max and I worked together. He is still a law enforcement officer so he is still on the side of the angels, but I was a prosecutor, way back when.

And, Max, it is wonderful to see you.

I know the witnesses are at the ready with statistics on methamphetamine and the problems permeating our country. When I think of methamphetamine, my mind doesn't go to statistics. It doesn't go to a debate between pharmaceutical companies and law enforcement. It goes to a couple named Ann and Ray Emery in the Drayton community in Spartanburg County, South Carolina. Ann and Ray Emery were a beautiful couple. They were active in their community, active in their churches, deeply in love with one another, and full of life.

They had a next-door neighbor named Andres Torres. Andres Torres was a troubled person with a long criminal history, and an addiction to methamphetamine. He knocked on their door one afternoon and said he needed a ride to the grocery store to get some food, so Ray Emery, being the decent, kind, human being that he was, stopped what he was doing, and took Andres Torres to the store. And he even did one better than that; he bought the groceries for Andres Torres. That was the kind of person Ray Emery was, kind, selfless, always ready to help a neighbor, even a neighbor as troubled as Andres Torres.

About a week later, Andres Torres came back to the Emery home, but this time, he didn't come in the afternoon. He came in the middle of the night under cover of darkness. He crept in through a side door. He walked into Ann and Ray Emery's bedroom and began to bludgeon Ray Emery with a hammer. Nineteen times he raised the hammer and struck the face or the head of another human being. Ray Emery's face was unrecognizable as a human face in the crime scene photos. He is laying there in a pool of blood on his bed with his skull fractured and his left arm is reaching out toward his wife. His body is on the floor. She too had been bludgeoned with a hammer, both of her eyeballs were absent. The bridge from her mouth was down into her neck, having been beaten there by a hammer, and she was raped postmortem.

So statistics are fine. They certainly have their place. If you want to see the carnage of methamphetamine, I invite you to come look at the crime scene photos with me from the State of South Carolina v. Andres Torres.

Methamphetamine requires ephedrine and pseudoephedrine as precursors. These two drugs are commonly found in medicines that are also extremely beneficial to law-abiding citizens. It is interesting at least for me to note that I believe that ephedrine and pseudoephedrine were both part of the Federal schedule prior to 1976, and methamphetamine, at least to my knowledge, was nonexistent prior to then.

I don't know what the answer is. On the one hand, we know that those who seek to break existing laws, whether it be controlled substances laws or guidelines for the sale of ephedrine or pseudoephedrine, are adept at getting around whatever barriers we impose. On the other hand, it seems that 99 percent of our fellow citizens who follow the law and act lawfully are continually asked to change their behavior in an effort to combat those who cannot or will not conform to the law.

So I look forward to hearing from our witnesses. Methamphetamine is an epidemic. You don't have to be a law enforcement officer or a prosecutor to know that. If the consequences of using and abusing this drug were just confined to the drug addicts themselves, it would be calamitous enough, but the consequences are far reaching, even ending the lives of beautiful couples who happen to live next door.

So, with that, I would recognize the gentleman from Illinois the ranking member, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And I thank you for holding today's hearing. Illicit drug use is one of the most challenging difficulties facing our society. It de-

stroys families, individuals, careers, dreams, hopes, and tears at the very fabric of our basic communities. The damaging effects of meth that began in the Western States have now infiltrated my State of Illinois, and my hometown of Chicago.

According to the United States Department of Justice, meth is the primary drug threat to central and southern Illinois but is increasing in the Chicago area. The State recently ranked fourth in meth-related arrests. Estimates place the cost of the meth epidemic to Illinois alone at about $2 billion per year, when crime, loss of productivity, incarcerations, and the impact on families and children are taken into account. These are indeed stunning numbers. Our response in large has been to lock these folks up. The United States leads the world in the number of incarcerated people. There are some 2 million Americans in jail or prison. The United States incarcerates more people for drug offenses than any other country.

With an estimated 6.8 million Americans struggling with some sort of drug dependence, our prison populations will burst at the seams if we continue with this course. I submit that drug treatment can and should be fully incorporated into the criminal justice system. Treatment services for addicts on the street and even those incarcerated must become more of a priority. Treatment must become a part of probation, parole, and drug code participation. By working together, substance abuse treatment providers and criminal justice system officials can optimize their resources.

Mr. Chairman, we want individuals to become productive citizens and return to activities that benefit society.

A substance and mental health services administration study found that treatment decreases arrests for any crime by 64 percent. After only 1 year, the use of welfare declines by 10.7 percent, while employment increased 18.7 percent. The numbers show it. Treatment can have a defining effect on a person, on a community, and on our country.

Imagine if the dollars spent on incarceration could be put to other uses. I am certain that law enforcement officials here today encourage treatment as well. They see the same individuals withering away time and time again. These people could have been something or done something else with their lives.

I applaud our law enforcement officials for coming. I respect what it is that you do. You represent the on-the-ground methamphetamine fight in our communities and more often than not put yourselves in harm's way. The intense battle against meth in rural America mirrors the urban fight against crack cocaine that dominated urban America in much of the 1990s and on into today.

I look forward to the testimony of our witnesses.

Mr. Director, it is good to see you again, and I want to thank you for spending the day with us in Chicago exploring the different facilities and approaches that we have tried to make real and implement in our hometown. I thank you for the tremendous work that you do and look forward to your testimony and that of the other witnesses.

Mr. Chairman, I yield back the balance of my time.

Mr. GOWDY. I thank you the gentleman from Illinois.

Members may have 7 days to submit opening statements and extraneous material for the record.

We now welcome our first panel, The Honorable, Gil Kerlikowske, is the director of the Executive Office of the President's Office of National Drug Control Policy.

Sir, welcome.

Pursuant to committee rules, all witnesses must be sworn in before they testify. So I would respectfully ask you to rise and raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth and nothing but the truth?

Let the record reflect the witness answered in the affirmative. Thank you. You may be seated.

Witnesses typically have 5 minutes for opening statements. There should be a panel of lights. If there is not, I will get you to rely on your internal clock, and with that, welcome.

WITNESS STATEMENTS

STATEMENT OF THE HONORABLE R. GIL KERLIKOWSKE

Mr. KERLIKOWSKE. Thank you very much. If my internal clock runs a little behind, if you will let me know.

Thank you, Chairman Gowdy, Ranking Member Davis, and members of the subcommittee for the opportunity. Having spent 9 years as a the chief of police in the Northwest, I am very much aware of the significant health and public safety problems that result from methamphetamine use.

Well, the national data indicate the number of current meth users in the United States has dropped significantly in the past several years. What these data don't capture, of course, is the considerable regional and local variations in methamphetamine production and use. Meth continues to be a drug of significant concern for both the public health and safety of many communities throughout this country. And frankly, given the regional patterns associated with meth, ONDCP was not as forward-thinking in recognizing the problem and proposing efforts to deal with it.

The law enforcement intelligence reporting indicate the availability of methamphetamine in general is increasing in markets throughout this country. There is evidence of significant declines in price, and significant increases in purity of the drug. Mexico remains the primary source of domestic meth supplies. From 2008 to 2011, the number of meth seizures along the border increased nearly 400 percent. Restrictions on precursor chemicals by the Mexican government had some initial success, but they appear—do not appear to be as effective in the long run. Drug trafficking organizations have found ways to work around them.

The increase in the supply of Mexican methamphetamine is paralleled by a growth in domestic meth production over the past several years. U.S. meth lab seizures more than doubled between 2007 and 2010, and these labs pose a major threat to public safety and the environment, as well as a significant burden on already busy law enforcement and first responders.

And the growth in domestic production is attributable to increased numbers of small meth labs and the shift in lab size is largely attributable to restrictions placed on precursor chemicals

that made it difficult to obtain large quantities of the precursors that fueled the super labs.

However, as in Mexico, producers here in this country, found ways to circumvent the restrictions. Individual or smaller scale criminal groups of organized smurfing operations, where individual purchasers acquire illegal quantities of the chemicals through multiple purchases from several retail locations.

While the administration supports several important efforts to combat methamphetamine production and trafficking, and to prevent and treat the drug as directed by Congress, our National Youth Anti-drug Media Campaign targets those areas of the country hardest hit by meth and delivers messages conveying the risks of meth use and the importance of treatment and the importance of recovery. And the administration is committed to working with the criminal justice system to reduce this problem.

Our HIDTA, our High Intensity Drug Trafficking Area programs, which are supported by ONDCP are very much focused on this. The National Methamphetamine and Pharmaceuticals Initiative is a HIDTA program working on the problem. Current Federal restrictions on pseudoephedrine as a result of Congress' Combat Methamphetamine Enforcement Act along with a majority of States with controls in place were originally intended to cut down on production.

However, the restrictions are showing some diminishing effectiveness. In an effort to address the resurging threats some States implemented electronic sales monitoring systems for pseudoephedrine. However, there is growing evidence that these electronic efforts have been unable to contain a resurgence of the small-scale meth production.

Domestic producers can—domestic producers can and have been circumventing the system by simply employing large numbers of buyers with multiple fake IDs. Another prescriber control is to reduce pseudoephedrine availability through scheduling. And in 2006, Oregon made pseudoephedrine a schedule III controlled substance, prescription only. Methamphetamine laboratories seizures declined dramatically, from 190 to 11, from 2005 to 2011. Mississippi has had similar excellent responses, although their law has only been in place since July 1, 2010. The administration is dedicated to working closely with the Members of Congress on this problem. We have to focus on these strategies, and I look forward to answering any questions.

[The prepared statement of Mr. Kerlikowske follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

"Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence"

Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia,
Census and the National Archives

Tuesday, July 24, 2012
9:30 a.m.
2203 Rayburn House Office Building

Written Statement
of
R. Gil Kerlikowske
Director of National Drug Control Policy

STATEMENT OF
R. GIL KERLIKOWSKE
DIRECTOR
OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT

before the

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES
UNITED STATES HOUSE OF REPRESENTATIVES

"METH REVISITED: REVIEW OF STATE AND FEDERAL EFFORTS TO SOLVE THE DOMESTIC METHAMPHETAMINE PRODUCTION RESURGENCE"

JULY 24, 2012

Thank you very much Chairman Gowdy and Ranking Member Davis for the opportunity to testify on this important subject. I look forward to today's discussion and also working closely with both of you on drug issues in your home States and across the country.

Introduction

Decades of scientific study show that drug addiction is not a moral failing on the part of the individual—but a disease of the brain that can be prevented and treated. And while smart law enforcement efforts will always play a vital role in protecting communities from drug-related crime and violence, the Obama Administration has remained clear that we cannot arrest our way out of the drug problem through an enforcement-centric "war on drugs."

As you are also aware, I am charged with producing the *National Drug Control Strategy* (*Strategy*), which directs the Nation's anti-drug efforts and establishes programs, a budget, and guidelines for cooperation among Federal, state, and local entities. The Administration's inaugural *Strategy*, released in May 2010, committed to reducing drug use and its consequences through a science-based public health approach to policy. The *Strategy* established specific goals by which to measure our success. The *Strategy* included action items that comprehensively address all areas of drug control. In April, the Obama Administration released the 2012 *Strategy*, which builds upon the progress achieved since the release of the inaugural *Strategy* and is guided by three facts: addiction is a disease that can be prevented and treated; people with substance use disorders can recover; and innovative new criminal justice reforms can stop the revolving door of drug use, crime, incarceration, and re-arrest.

Our efforts are balanced and incorporate new research and smarter strategies to better align policy with the realities of drug use in communities throughout this country. Addiction is a complex, biological, and psychological disorder. It is chronic and progressive, and negatively

affects individuals, families, communities, and our society as a whole. In 2010, 23 million Americans ages 12 or older needed treatment for an illicit drug or alcohol use problem. However, only 11 percent received the necessary treatment for their disorders.[1]

Treatment is effective, and recovery is possible. Three decades of scientific research and clinical practice have proven that treatment for drug addiction is as effective as treatment for most other chronic medical conditions, such as diabetes, hypertension, and asthma. We need to change the conversation in this country to emphasize the importance and effectiveness of treatment and recovery in overcoming this disease, and each of us must take personal responsibility for not using drugs, for seeking treatment if we have a problem, and for committing to recovery from substance abuse.

Thousands of Americans lose their lives each year because of illicit drug use. I am deeply troubled by the recent sharp increases in drug-related deaths. In 2009, the latest year for which data are available, drug-induced deaths were the leading cause of injury death in the United States, exceeding deaths due to traffic crashes and gunshot wounds.[2]

In addition to identifying ways to improve access to care for those struggling with addiction, the Administration is exploring and expanding alternatives to incarceration for low level offenders, such as proven programs like local drug courts and promising new probation-based initiatives like Hawaii's Opportunity Probation with Enforcement (HOPE). HOPE is a probation program that delivers swift, certain, but modest punishments to deter crime and drug use. It has demonstrated success in reducing jail time and recidivism, and has also improved abstinence rates. The HOPE program has also shown significant promise in methamphetamine-using populations, a traditionally difficult-to-treat population, and is currently being expanded throughout the country.[3] While treatment-focused programs like drug courts require training, technical assistance, and support from local treatment providers, studies have demonstrated that they are cost effective, especially when compared to traditional incarceration of non-violent drug offenders.[4] The Administration is committed to supporting and expanding drug courts and is currently supporting research into probation programs like HOPE to ensure these alternatives are available to break the cycle of incarceration for drug offenders.

This statement addresses one important aspect of our national effort to reduce drug production, trafficking, and overall demand: methamphetamine, a highly-addictive drug that has affected the lives of millions of Americans. Methamphetamine continues to pose a very significant threat to the health and safety of our citizens. Although our drug consumption surveys continue to show reduced use, I believe that increased production both in Mexico and the United States threatens to reverse that progress. The Office of National Drug Control Policy (ONDCP) and my colleagues in the Federal Government very much appreciate the opportunity to highlight this threat and to discuss with you how we can continue to work together to address it.

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[1] Results from the 2010 National Survey on Drug Use and Health: National Findings, Substance Abuse and Mental Health Services Administration (SAMHSA), 2010, http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.pdf.

[2] National Center for Health Statistics. (2012). National vital statistics reports: Deaths: Final Data for 2009. Centers for Disease Control and Prevention: Washington, DC. Highlights/Detailed Tables available: http://www.cdc.gov/nchs/data/dvs/deaths_2009_release.pdf

[3] Hawken, AD & Kleiman, M (2009) Managing drug involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE. National Institute of Justice, Washington, DC.

[4] U.S. Government Accountability Office, "Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes." GAO. [February 2005]. Available http://www.gao.gov/new.items/d05219.pdf

Methamphetamine Availability and Production

Methamphetamine continues to be a drug of significant concern for both the public health and safety of many communities throughout the United States. While national data indicate that the number of current methamphetamine users in the United States has dropped significantly in the past several years, from approximately 731,000 current users in 2006 to approximately 353,000 in 2010,[5] these data do not capture the considerable regional and local variations in methamphetamine use, nor do they reflect the increases we have seen over the last 24 months in methamphetamine trafficked across the Southwest Border.

Law enforcement and intelligence reporting, as well as seizure, price, and purity data, indicate that the availability of methamphetamine in general is increasing in markets throughout the United States.[6] The high availability of methamphetamine in our country is attributable to a combination of factors. A strong Mexican-based production and distribution infrastructure, combined with growing numbers of domestic manufacturing operations ensure that domestic methamphetamine supplies remain high. This conclusion is supported by evidence of significant declines in price per pure gram of methamphetamine since late 2007, caused by significant increases in purity of the drug available.[7,8]

Mexico remains the primary source of domestic methamphetamine supplies, with the latest data indicating dramatic increases in the flow of Mexican methamphetamine into the United States. Mexican-based producers are operating at high production levels, which has allowed for expansion of distribution into the United States over the past several years.[9] In fact, from December 2007 to December 2011, the 12-month moving average of meth seizures along the Southwest Border increased approximately 350 percent.[10] Law enforcement reporting, laboratory seizure data, and sustained upward trends in Mexican methamphetamine availability in U.S. markets all combine to support these conclusions.

Although efforts undertaken by the Government of Mexico (GOM) to address methamphetamine production in the country were initially very effective, this success has eroded considerably over the past several years. Between 2006 and 2007, import and other restrictions placed on precursor chemicals such as pseudoephedrine and ephedrine by the GOM severely disrupted Mexican production capabilities. Overall, we have heard reports from law enforcement indicating that precursor restrictions have decreased the quantities of pseudoephedrine available to producers.[11] However, Mexican drug trafficking organizations (DTOs) have found ways to work around these restrictions, including smuggling precursors into Mexico in violation of GOM import

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[5] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings.* U.S. Department of Health and Human Services. [September 2011]. Available: http://www.oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#Ch2

[6] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=38

[7] Ibid. National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=38

[8] Drug Enforcement Administration. System to Retrieve Information from Drug Evidence (STRIDE).

[9] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=38

[10] National Seizure System, El Paso Intelligence Center, extracted 5/10/2012

[11] Office of National Drug Control Policy. *Report to Congress: Use of High Intensity Drug Trafficking Areas Program Funds to Combat Methamphetamine Trafficking.* Executive Office of the President. [May 2012].

restrictions, often from China and India.[12] Large seizures of mislabeled or hidden pseudoephedrine being smuggled into Mexico indicate traffickers are attempting to circumvent these restrictions.[13] The precursor restrictions have also driven Mexican DTOs to alternative production methods. Mexican producers are importing phenylacetic acid, a chemical that allows for a derivation of methamphetamine precursors, effectively working around pseudoephedrine and ephedrine restrictions.[14] In addition, Mexican producers are now using and refining the phenyl-2-propane (P2P) method, a technique originally used by U.S. outlaw motorcycle gangs to produce methamphetamine. Data suggest that Mexican DTOs have improved this process and are producing methamphetamine of potency similar to that of other production methods.

The increases in the supply of Mexican methamphetamine are paralleled by growth in domestic methamphetamine production over the past several years. After GOM's precursor restrictions severely disrupted Mexican production capabilities in 2006 and 2007, U.S. production and distribution networks grew to meet domestic demand for the drug to compensate for reduced supply from Mexico. However, as Mexican production has reemerged and increased, U.S. production has showed few signs of decline. In fact, U.S. methamphetamine lab seizures have increased from approximately 3,100 in 2007 to nearly 6,400 in 2011, an increase of over 100 percent.[15,16] These domestic labs represent a major threat to public safety and the environment, as well as a significant burden on the already busy law enforcement officers responsible for locating and cleaning up these toxic labs.

At the same time there have been significant changes in the regional distribution, production capacities, and methods involved in domestic production of methamphetamine. This growth in domestic production is largely attributable to increased numbers of small-scale methamphetamine labs throughout the country. In 2004, the peak of domestic meth lab activity in the United States, the West Coast had significant lab activity.[17] However, methamphetamine lab activity has declined in the West and has risen in the Midwest and South in the last several years.[18] But simple counts of lab incidents do not tell the full story. The production capacity of the seized labs has declined. Currently, approximately 80 percent of the methamphetamine labs seized in the U.S are of the smallest capacity category documented, i.e., less than 2 ounces.[19] Most of the remaining laboratories seized were also relatively small, with capacities between 2 and 8 ounces per production cycle. While the shift in production is a positive sign, small-scale domestic labs account for only a small portion of the U.S. supply, and their proliferation can stimulate new local markets for methamphetamine where the drug was previously unavailable.[20]

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[12] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=23
[13] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=68
[14] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=68
[15] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=40
[16] National Seizure System, El Paso Intelligence Center.
[17] National Seizure System, El Paso Intelligence Center.
[18] National Seizure System, El Paso Intelligence Center.
[19] National Seizure System, El Paso Intelligence Center.
[20] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Movement." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=29

This shift in lab size is largely attributable to restrictions placed on precursor chemicals, like those imposed by the Combat Methamphetamine Epidemic Act (CMEA) and state-level restrictions, which have made it increasingly difficult for producers to obtain large quantities of precursors necessary to operate large scale "superlabs".[21] However, as in Mexico, U.S. producers have found ways to circumvent many of these restrictions. Individual or smaller-scale criminal groups have organized "smurfing" operations to source large quantities of pseudoephedrine and other precursor chemicals.[22] "Smurfing" operations use individual purchasers to acquire illegal quantities of precursor chemicals through multiple purchases from several retail locations, effectively circumventing the monitoring and control provisions of the CMEA. Law enforcement has identified a number of significant smurfing operations, including one in which an organization purchased over 60 pounds (almost 27,216 grams) of pseudoephedrine tablets in less than 30 days by traveling to multiple retail locations such as convenience stores and highway rest stops.[23] In addition, the domestic increase in small-scale labs is attributable to the "one-pot" production method, which produces relatively small quantities of methamphetamine from pseudoephedrine products without the presence of a full-scale laboratory. And as in Mexico, law enforcement has reported that some U.S. producers have shifted to the P2P method, which enables production without the need for pseudoephedrine or ephedrine.

As you know, domestic methamphetamine labs pose a number of serious risks to the health and safety of law enforcement officials, the general public, and the lab operators themselves. Clandestine labs can threaten the physical safety of their operators and members of the community, with high potential for explosions, fires, chemical burns, and toxic fumes. The array of dangerous chemicals used in the methamphetamine production process creates dangerous, volatile toxic sites. Data from the National Seizure System show that there were 263 explosions or fires at methamphetamine production sites in 2010, compared with 186 in 2009; in 2011 there were 217 explosions or fires.[24] In addition, methamphetamine production poses severe environmental risks. For each pound of methamphetamine produced, the manufacturing process can yield significant quantities of toxic waste. Lab operators frequently dump this waste into the ground, sewers, or nearby streams and rivers. The water used to put out lab fires can also wash toxic chemicals into sewers. Contamination of the ground and local water supplies can last for several years, and cleanup of the lab sites themselves can cost state and local authorities hundreds of thousands of dollars annually, stretching already tight budgets.

Perhaps one of the greatest concerns associated with clandestine methamphetamine labs is the dangers posed to children in these dangerous environments. Public safety officials have frequently encountered children who have been directly exposed to the hazards of clandestine drug labs. Some children have dangerous chemicals or traces of illicit drugs in their systems, while others have suffered burns to their lungs or skin from chemicals or fire. In the most disturbing cases, children have been injured in lab explosions and fires, while others have been

[21] The term "superlab" refers to a laboratory that generates 10 pounds or more of methamphetamine per production cycle.
[22] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=40
[23] Office of National Drug Control Policy. *Report to Congress: Use of High Intensity Drug Trafficking Areas Program Funds to Combat Methamphetamine Trafficking*. Executive Office of the President. [May 2012].
[24] National Seizure System, El Paso Intelligence Center.

neglected or abused by adults living at lab sites. These deplorable conditions have led to the development of Drug Endangered Children (DEC) programs across the country. DEC programs help coordinate law enforcement, medical, and child welfare services to ensure children discovered in methamphetamine labs or other drug production operations receive much-needed care.

The recent increases in domestic methamphetamine production prove that efforts to reduce drug availability cannot focus solely on foreign production and distribution networks. We must address domestic production through initiatives that can successfully reduce production and distribution within our borders. Community-oriented policing and innovative enforcement methods can help eliminate street-level distribution and effectively utilize law enforcement resources to ensure public safety and community quality of life.

Efforts to Prevent Production and Use of Methamphetamine

The Administration supports several important efforts to combat methamphetamine production and trafficking, and to prevent and treat use of the drug. By emphasizing this balanced approach, we are implementing a national strategy that recognizes the role of enforcement, along with prevention and treatment, to reduce the availability and demand for methamphetamine and other drugs. A number of these efforts are effectively targeting methamphetamine production and use.

Since 2007, ONDCP's National Youth Anti-Drug Media Campaign has supported a national Anti-Meth Campaign through TV, radio, print, and online anti-meth advertising in areas of the country hardest hit by meth. The anti-meth messages are aimed at young adults ages 18-34, as national survey data indicate that young adults, with an average age of first use of methamphetamine and other stimulants of approximately 21 years,[25] are far more likely to use meth than teens or any other age group. The Anti-Meth Campaign targets those areas of the country hardest hit by meth and delivers messages conveying the risks of meth use, the effectiveness of treatment, and the possibility of recovery from meth addiction. The Campaign's advertising and outreach have included messages that focus on preventing meth use and raising awareness about the benefits of treatment, and encouraging friends and family of meth users to seek treatment for their friend or loved one. The Campaign makes its anti-meth ads available as free resources for community organizations to use in their local markets. This effort provides parents, youth, and other state, tribal, and community leaders with the knowledge and tools necessary to help prevent methamphetamine use, help those struggling with methamphetamine addiction find the care they need, and reduce the drug's corrosive influence within their communities.

The Administration is also taking a number of steps to improve access to substance abuse treatment across the country. To quickly improve intervention and treatment services, we are exploring ways to enhance services delivered by primary healthcare providers. One current effort involves enhancing substance abuse care in Federally supported community health centers

[25] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings.* U.S. Department of Health and Human Services. [September 2011]. Available: http://www.oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#Fig5-3

supported by the Health Resources and Services Administration (HRSA) and centers supported by the Indian Health Service (IHS). Expanding the capacity of these facilities to identify and address substance abuse issues will improve substance abuse intervention and treatment services, particularly for under-served populations, including Native American and Native Alaskan populations.

Ongoing treatment and recovery support is critical to assisting patients in maintaining their recovery after participating in a treatment program. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Access to Recovery (ATR) program is a voucher-based system that provides patients with access to a large pool of service providers, including mental health clinics, social services, and housing agencies, as well as faith-based and community organizations. By providing additional options for treatment and recovery support, these vouchers enable individuals to obtain care that is convenient and effective for them, helping address some of the obstacles of limited treatment availability. In 2010, SAMHSA awarded a new round of funding to 30 ATR state and tribal grantees, all of which were fully operational by early 2011.

The Administration is committed to working with the criminal justice system to reduce methamphetamine-related crime and improve public health and safety. The 28 regional High Intensity Drug Trafficking Area (HIDTA) programs located throughout the Nation, supported by ONDCP, are dedicated to reducing the production, trafficking, and use of methamphetamine. HIDTA-funded task forces, composed of Federal, state, local, and tribal law enforcement officers, are helping lead the effort to discover and dismantle methamphetamine labs across the country. In 2011 alone, HIDTA-funded initiatives seized 1,485 methamphetamine laboratories, approximately 23 percent of the total number seized nationwide.[26] In addition to the denied revenue associated with the dismantlement of these laboratories, HIDTA-funded efforts removed an estimated wholesale value of $102.7 million of methamphetamine and $126 million of crystal methamphetamine from the market in 2011.[27] Moving forward, HIDTA-funded initiatives are increasing their focus on investigations of trafficking of methamphetamine, largely due to the increased difficulty and time required to seize growing numbers of smaller-scale labs.

The National Methamphetamine & Pharmaceuticals Initiative (NMPI) is one HIDTA program focused on reducing methamphetamine production and distribution nationally. With an Advisory Board consisting of four Federal and six state and local representatives from various regions of the United States, NMPI shares regional information and identifies enforcement priorities to reduce methamphetamine trafficking throughout the country. NMPI is supporting efforts to control precursor chemicals such as pseudoephedrine, and provides training to Federal, state, local, and tribal personnel on methamphetamine drug crimes, trends, drug-endangered children, and best practice solutions to address other methamphetamine-related issues.

The Administration is committed to increasing treatment capacity and improving access for those in need of substance abuse services, including those for methamphetamine dependency. By balancing improvements in these areas with smarter strategies in law enforcement and criminal

[26] Office of National Drug Control Policy. *Report to Congress: Use of High Intensity Drug Trafficking Areas Program Funds to Combat Methamphetamine Trafficking*. Executive Office of the President. [May 2012].
[27] Office of National Drug Control Policy. *Report to Congress: Use of High Intensity Drug Trafficking Areas Program Funds to Combat Methamphetamine Trafficking*. Executive Office of the President. [May 2012].

justice, we hope to more effectively address the challenges posed by methamphetamine and other drugs.

Efforts to Control Precursor Availability

As many in Congress have recognized, one of the most promising methods for disrupting methamphetamine production involves strengthening control of precursor chemicals used in its manufacture. Methamphetamine production operations typically obtain large quantities of precursors like pseudoephedrine through illicit means. By restricting the illicit pathways through which these chemicals are acquired, we can dramatically reduce methamphetamine production capacity, lower street availability of the drug, and thereby significantly reduce the public health and safety costs associated with its manufacturing and use.

As you know, the Drug Enforcement Administration (DEA) cannot administratively schedule either pseudoephedrine or ephedrine, since they are specifically exempted under the Controlled Substances Act (CSA) from the schedules of controlled substances. With this in mind, varying degrees of precursor control have been implemented both internationally and here in the United States, with some demonstrated success in reducing methamphetamine availability and production. However, it is equally important to note that these efforts face limitations in reducing methamphetamine production.

As discussed earlier, methamphetamine availability in the United States originates from both international DTOs and domestic clandestine labs. The declines in methamphetamine production and U.S. availability in 2007 and 2008 are largely attributable to the GOM's precursor chemical restrictions, which included a comprehensive ban on pseudoephedrine use and distribution. However, by late 2008, and continuing to the present, Mexican DTOs had already started to adapt their operations: smuggling regulated chemicals via new routes; importing non-regulated chemical derivatives instead of precursor chemicals; using alternative production methods; and, when the precursors used in the alternative (P2P) production methods became more tightly regulated, switching to derivatives of those chemicals.

Restrictions on pseudoephedrine in the United States have also had diminishing success in reducing methamphetamine production. Current Federal restrictions, along with a majority of states with controls in place, were originally intended to cut down on methamphetamine labs and their production capacities. However, these restrictions are showing diminishing effectiveness in reducing domestic methamphetamine production. Current data show a significant rise in meth labs across the United States. Drug traffickers and others are evading Federal and state laws and are domestically producing methamphetamine with increasing frequency. Law enforcement officials from throughout the Nation report that the pseudoephedrine used for methamphetamine production in their areas can be sourced to local and regional smurfing operations.[28] These activities rapidly deplete limited and valuable law enforcement resources, and fuel the continued growth in domestic labs.

[28] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Availability." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=40

While we must certainly consider the public health benefits of convenient access to cold medicines such as pseudoephedrine, the considerable threat to public health and safety posed by domestic methamphetamine labs cannot be ignored. In an effort to address this resurging threat, some states implemented electronic pseudoephedrine sales monitoring systems. These systems track consumer purchases of pseudoephedrine-based medications and seek to ensure, in real time, that purchases are limited to legal amounts. Kentucky, Oklahoma, and Arkansas are among the 26 states that have implemented these tools in an attempt to reduce diversion of precursor chemicals for methamphetamine production. Kentucky was one of the first to implement a statewide system, ensuring consumer purchases made anywhere in the State comply with legal restrictions. These electronic tracking systems are intended to prevent smurfing and reduce illegitimate pseudoephedrine purchases. However, even with these tracking systems in place, small-scale methamphetamine production has increased in several states.[29] Domestic producers can and have been circumventing these systems by employing more buyers or using buyers with multiple fake or stolen IDs to purchase pseudoephedrine products in small, legal quantities. The sheer volume and inconsistent quality of data in these electronic databases severely hinder the ability of law enforcement to investigate cases of smurfing. The leads provided by tracking systems require extensive law enforcement resources to fully investigate and then effectively prosecute violators. Many would argue that electronic tracking systems do not prevent the creation or expansion of meth labs. Further, these electronic tracking systems are more reactive and are not reflective of the modern, more preventive approach to law enforcement.

A prescription requirement for pseudoephedrine may be a promising tool in a comprehensive plan to address methamphetamine production. Facing a similar threat from domestic lab production, the State of Oregon in 2006 made pseudoephedrine a Schedule III controlled substance, making it prescription only, as it was prior to 1976. There was extensive debate in Oregon as to whether this law would prevent smurfing and methamphetamine labs, and whether there would be public outcry or other adverse consequences. Six years later, the results are very encouraging. Methamphetamine laboratory seizures declined dramatically from 190 in 2005 to 11 in 2011,[30] suggesting a significant reduction in labs operating in the state, and thus in the public health and safety dangers posed by these labs. Prior to the prescription requirement, some constituents expressed concerns over potential problems with access to medication and health care costs, but in the time since the enactment of the prescription requirement, there has been relatively little negative reaction from patients, pharmacists, or healthcare providers.

Mississippi also implemented a prescription requirement for pseudoephedrine and ephedrine products.[31] Only in effect since July 1, 2010, we cannot draw long-term conclusions about the effect of the law. However, laboratory seizure data are showing positive signs. In 2010, Mississippi reported 698 seizures in 2010 but only 259 in 2011, a 63 percent decrease.[32] Law enforcement agencies from the State have also reported decreases in methamphetamine

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[29] Drug Enforcement Administration. "Methamphetamine Lab Incidents, 2004-2011" U.S. Department of Justice. [2012]. Available: http://www.justice.gov/dea/concern/map_lab_seizures.html

[30] Drug Enforcement Administration. "Methamphetamine Lab Incidents, 2004-2011" U.S. Department of Justice. [2012]. Available: http://www.justice.gov/dea/concern/map_lab_seizures.html

[31] Mississippi House Bill 512 (as signed by Governor Barbour, 2/11/10); "Governor Barbour Signs Bill Targeting Meth Manufacturing." GovernorBarbour.com. [February 2010]. Available: http://www.governorbarbour.com/news/2010/feb/2.11.10BarboursignsHB512.html

[32] Drug Enforcement Administration. "Methamphetamine Lab Incidents, 2004-2011" U.S. Department of Justice. [2012]. Available: http://www.justice.gov/dea/concern/map_lab_seizures.html

production and methamphetamine-related arrests in the task force's area of responsibility since passage of the law. In addition, a number of municipalities in Missouri followed Oregon's lead in 2009, and preliminary reporting suggests some success in reducing methamphetamine production in these communities.

As a result of the successes achieved in Oregon and Mississippi, 16 states filed legislative bills in 2011 to enact prescription requirements for pseudoephedrine. However, none of the measures passed.

Internationally, in 2009, New Zealand recognized a need for additional pseudoephedrine controls to cut down on methamphetamine production and made pseudoephedrine a prescription-only drug, joining countries such as The Netherlands that have long banned pseudoephedrine-containing products from being obtained over the counter. New Zealand's government recognized that previously established restrictions were not effectively reducing methamphetamine production, and took the nationwide step of a prescription requirement.

This preliminary evidence suggests that additional restrictions on pseudoephedrine may have promise in reducing that threat. However, more work is needed to identify the policies that strike the appropriate balance between reducing the illicit use of pseudoephedrine and maintaining access for legitimate and safe use. By working closely with other agencies in the Federal community, consumers, public health and safety leaders, and the health care products industry, we can work through these challenges.

Conclusion

Methamphetamine poses a number of significant challenges for policymakers at the local, state, and Federal levels. The Obama Administration is dedicated to working closely with Congressional and other leaders to identify and implement the best solutions as quickly and effectively as possible. We know methamphetamine production and trafficking severely degrade the public health and safety for many of our citizens, but no single approach will be effective alone. Instead, we must focus on proven strategies that effectively eliminate domestic methamphetamine labs, focus on prevention, early intervention, and treatment, as well as work with our international partners to target and dismantle large-scale drug trafficking groups that produce and import methamphetamine into the U.S. By doing so, we can cut down on methamphetamine production and more effectively reduce the dangers to the most heavily affected communities and regions in the United States.

Placing limitations on access to precursor chemicals is one piece of a comprehensive strategy to curb methamphetamine use, and I look forward to working closely with you and the other members of the Subcommittee to address this important issue. Thank you again for the opportunity to testify here today and for your support on this vital concern.

Mr. GOWDY. Thank you, Director.

The chair would now recognize Dr. DesJarlais for his questions.

Mr. DESJARLAIS. Good morning, and thank you for being here.

Let's just kind of try to go through a bunch of questions because we have limited time. Does the ONDCP have an official position with respect to the best way to solve domestic meth production problems?

Mr. KERLIKOWSKE. We have a position as far as it has to be holistic. We have to work on getting the message to these young people, particularly in about that 20- or 21-year age limit where oftentimes they begin to be involved with methamphetamine. We know that treatment works for those people that can get back into being productive citizens, and we know enforcement can work, not only working with countries to ban precursors—and I will be traveling to China in September. Mexico has dismantled a number of laboratories, but they need additional assistance from the United States. And lastly, working with local and domestic law enforcement here in the United States, we have seen some real progress, particularly when I mentioned Mississippi and Oregon.

Mr. DESJARLAIS. Okay, I would like to talk more about those States as opposed to States that have instituted other point-of-sale restrictions or tracking systems. What in your experience, is working best? Let's take Oregon and Mississippi, compare them to States like Tennessee who has tracking methods. What are you finding? What is the data showing——

Mr. KERLIKOWSKE. Well, the data is showing that the number of lab incidences has been reduced in those two States in which the precursor chemical has been made a prescription only. And you have some experts that—behind me—that really know their particular State data, very, very well.

But I will tell you from my law enforcement hat, from many years, law enforcement has had a reduction in resources, and giving more leads and more information isn't quite as important as preventing the problem. And it seems like Oregon and Mississippi show great promise in preventing the problem.

Mr. DESJARLAIS. I think initially when Oregon was probably first on board to do that, they did not have the same number of border States and for example, Tennessee has seven. Now Mississippi, I think, did have more border States, and they showed similar results?

Mr. KERLIKOWSKE. They have shown a decrease, and I believe the director of the Mississippi narcotics unit is on the next panel.

I would tell you that what I have seen in Oregon, in particular in the Portland area, is that it is so easy to cross the bridge into my own State of Washington and purchase the precursors, and that is where oftentimes we see part of the problem, so I think that there is an important——

Mr. DESJARLAIS. Okay. Can the same reduction be shown in the States that have more sophisticated tracking systems or electronic logbooks? Are they showing a decrease, or is it steady or on the incline or what is happening there?

Mr. KERLIKOWSKE. So the decrease has been in the super labs, the large labs that produce a lot— a lot of methamphetamine. The

increases in all of these labs, regardless of the State, is in the small use of a pop bottle.

Mr. DESJARLAIS. Shake and bake.

Mr. KERLIKOWSKE. Shake and bake method. And so we are seeing that. So we are not seeing that quantity, but we are seeing these numbers. And of course, even when theses things are discarded on the highways or in playgrounds or anything else, they cause significant problems. They also drain public safety resources because of the hazardous materials responders that have to come out.

Mr. DESJARLAIS. Let me ask this because I don't know the answer, but as a primary care physician for 20 years who has prescribed a lot of cold medicines, does—I know the answer to this. Does Sudafed have any curative factors?

Mr. KERLIKOWSKE. I am probably not at all qualified to give you that answer, but I know there are plenty of medications for runny noses on the market that don't contain pseudoephedrine.

Mr. DESJARLAIS. What kind of kickback have they gotten in those two States from patients? Has it caused an increase in doctor visits and cost in terms of health care if they cannot get Sudafed over the counter and have to have a prescription?

Mr. KERLIKOWSKE. I am only familiar with Oregon, and one, it did not increase Medicaid costs. Number two, because it is a schedule III, that prescription can be called in, I mean, if you really need it.

Mr. DESJARLAIS. Right.

Mr. KERLIKOWSKE. That can be sent telephonically to the pharmacy to be filled.

Mr. DESJARLAIS. So if I have a patient that I know has severe allergies, runny nose, I don't have to make them come in for a visit. I can call in that prescription or give them a reasonable amount with the refills for 6 months or more, so it doesn't necessarily mean they have to come to the doctor?

Mr. KERLIKOWSKE. I believe so.

Mr. DESJARLAIS. Okay. I don't have a timer in front of me, Mr. Chairman, so you will have to—I see I am on yellow. Quickly, on the cleanup portion, you know, a lot of States, including Tennessee, ran out of funds, just literally overnight, just flipped a switch, and they were out of funds. Is there anything on the horizon to help these States in terms of dealing with meth cleanup? You talked about the shake and bake bottles being thrown in the ditch. If they don't have the money to clean them up, I am not saying law enforcement looks the other way, but these are dangerous chemicals to deal with, and what can we look forward to in terms of help and support in light of those funds running out?

Mr. KERLIKOWSKE. There is the request in for funding to replenish, and I think that—and it probably is not enough, given the number of small labs that are being seized, but there is some additional money there for them.

Mr. DESJARLAIS. Okay, I know my time is expired. We will talk maybe in the next panel about some of the solutions. I know in Tennessee, they went to multicounty storage containers and drastically reduced the cost of the meth cleanup by, gosh, it went from,

say, $10,000, to $2,500 for a cleanup with these storage containers. So we will talk more about that.

And thank you, Mr. Chairman, I yield back.

Mr. GOWDY. Thank the gentleman from Tennessee.

The chair will not recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Mr. Director, we know that the use of meth dropped significantly during 2007 and 2008, as States found ways to limit the supply and make it more difficult for individuals to acquire these key ingredients that were used to produce the concoction.

But now we see that there is a rise and increase again. Does that mean that people are finding ways to get around these restrictions and in terms of purchasing the ingredients or storing them or having them? If so, how are they doing that?

Mr. KERLIKOWSKE. You are absolutely right, Congressman.

When Congress acted with the Combat Meth Act and put the pseudoephedrine behind the counter, requiring the logbook, that did have an impact. At the same time, the government of Mexico banned the precursor chemicals.

Since then, two things have happened. One, the precursor chemicals are shipped in, either under forged documents into the country of Mexico, or they are shipped into places like Guatemala and then come up into the laboratories of Mexico. And then the methamphetamine makes its way here.

The second thing is that the smurfing that I talked about, in which large numbers of people with multiple fake identities can go from store to store and purchase the maximum amount of pseudoephedrine possible. And that is a way of getting around the Combat Meth Act and the logbook.

Mr. DAVIS. Are the sellers of these products required to maintain records and perhaps make those available to law enforcement officials to try and track what may be going on with the dealers?

Mr. KERLIKOWSKE. They are required to maintain the logbooks, and they are required to provide that logbook to law enforcement. The issue that my colleagues always talk about, though, of course, is that they would much rather see the crime or the incident prevented and the methamphetamine not made rather than devote law enforcement resources to try and track down information on what may often be a fake ID.

Mr. DAVIS. While I am a strong proponent of law enforcement techniques and approaches to try and really get a handle and keep the ingredients away or prevent individuals from having the meth to distribute, I guess I am also a strong proponent of treatment because, well, I just grew up a very simple way where we were told that an ounce of prevention is worth much more than a pound of cure. And it would seem to me that if we could provide treatment, and we know that treatment, according to all of the data that we have looked at, does in fact have a significant impact, how do we balance the law enforcement with the treatment in terms of resources and activities to make this the most comprehensive approach that we can?

Mr. KERLIKOWSKE. Congressman, I couldn't agree with you more, and I will be very surprised if any of my former law enforcement

colleagues that will be on the next panel would differ with you in the least. Law enforcement has been absolutely joined at the hip on both prevention and treatment programs, not only for methamphetamine but for other drugs. We have over 2,600 drug courts, and I know you are very familiar with them, having told me about the Chicago experience; 2,600 drug courts, many of whom deal with clients who in fact are addicted to methamphetamine. And I can tell you that the myth had always been that once someone was addicted to methamphetamine, they could never be cured. In my travels for this administration in 3 years, I have met literally hundreds of people who were severely addicted to meth and included some pretty drastic problems, dental problems, health problems, et cetera, that are back taking care of their families, back paying taxes, back being productive citizens. So we need to make sure that the program that we have is comprehensive.

Mr. DAVIS. Thank you very much, Mr. Chairman, and I yield back.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair would now recognize the gentleman from Florida, Mr. Mica.

Mr. MICA. Mr. Chairman, first of all, thank you for conducting this hearing. Unfortunately, part of the problem of the situation I think we are in is Congress, 4 years the other side of the aisle was in charge, and I don't recall a single hearing. I served as chair of the Criminal Justice Drug Policy Subcommittee from 1998 to 2000, been on the committee all my time, and I am trying to remember if there was even a single hearing relating to—well, there might have been some promotion of legalization of narcotics, but that might have been the only thing. So part of the problem of finding ourselves in this situation is that Congress wasn't doing its job.

Having been involved in trying to tackle this issue in the past, this is sort of catchup for me, and I have some questions. I think first you have to go after the source. If you are telling me Mexico is still the source and it continues to be the primary source, that is correct?

Mr. KERLIKOWSKE. Correct.

Mr. MICA. Precursors. I helped with Denny Hastert to develop a Plan Colombia, which we had basically the same situation we have in Mexico. Now, do we have a plan Mexico? Does the administration have a plan to deal, I mean, almost all of the narcotics and violence and precursors are coming out of Mexico, not to mention the wanton slaughter of tens of thousands of Mexican innocent citizens. Do we have a plan?

Mr. KERLIKOWSKE. We do have a plan, and I believe that President Calderon could not have been more courageous during his five and a half years.

Mr. MICA. Okay, there is a new president now, but he may have been courageous, but actually, you just testified that this stuff is still coming in, and they are subverting the process.

Mr. KERLIKOWSKE. Well, one, he took on banning those precursors, and they were pretty effective, but the drug traffickers have figured out two things.

Mr. MICA. But then you go to plan B. Do we have a plan B?

Mr. KERLIKOWSKE. Sir, the plan B would be to continue the increases of seizures along the borders. Mexico has increased the number of seizures of their laboratories within the government—or within the country, and they are working also to tighten their border, their southern border, where chemicals come into places like Guatemala and then make their way, the precursors, and then make their way——

Mr. MICA. So the other thing, too, is seizures. I am looking at this here, meth at DEA. You go back to 2004, 2005, and the Bush administration: 18,000 in 2004. And we are down to 10,000 seizures. Have we just become more tolerant? We don't—are you working with DEA to increase the seizures?

Mr. KERLIKOWSKE. Well, and the seizures are almost all done by Customs and Border Protection, as you well know, along the border.

Part of the reduction could also be the fact that we have about half of the users in this country that we did.

Mr. MICA. Well, again, blaming it on the users is something, or treatment is another thing.

Quite frankly, I believe when you get to treatment, you have lost the game. It is a—first stop in the precursors to put the stuff together. If it is coming through Mexico, we need a plan, and plan B, whatever it is. Is the law we passed in 2004 working? You said it is being subverted.

You know, we took some stuff off the shelf. We have got—but do we—does Congress need to look back at this, and I mean, I am a zero tolerance guy. I worked with Rudy Giuliani when he did that in New York and the residual is still there. You go after people, and you have tough enforcement, and you curtail the bastards, pardon my French, and stop them. And that is what you have got to do in this.

But when seizures are down, have you—has the administration arranged a meeting with the new administration yet on the drug issue, do you know?

Mr. KERLIKOWSKE. President-elect Pina Nieto has not named, to my knowledge, any of the people that will be in his cabinet to head up the——

Mr. MICA. Well, I think one of our priorities, and you should report back to this committee and Congress, is a meeting. This deserves the attention of the President of the United States. The slaughter across our borders now, the increase in use of methamphetamines, and then it looks like we are sleeping at the switch in enforcement, and we don't have a plan really to deal with this.

The last thing, too, the I helped set up the education program some years ago. I have no idea of the status of it. I have gotten waylaid on transportation issues, but part of it is education. Tell me the status of that program.

Mr. KERLIKOWSKE. The educational program, the National Anti-Drug Youth Media Campaign was not funded by Congress last year.

Mr. MICA. Do we have—when we did this, the deal I cut with Clinton was that half the money was going to come from the private sector or from public broadcasts. We own the air waves, and

they were supposed to provide some air-wave education. That is part of their responsibility under the FCC law to provide.

Do you have a program with them to provide some of that? We have on the air a meth program anti-meth program?

Mr. KERLIKOWSKE. We still, as required, spend 10 percent of that media money on meth. The most effective way——

Mr. MICA. But I mean getting them. They have the resources and the capability and the air waves and an obligation to use some of that for public education. Do you have a plan working with them now?

Mr. KERLIKOWSKE. We work with a partnership at drugfree.org and others, but we also know some of the most effective methods are through social media.

Mr. MICA. Yeah, well, do we have a plan?

Mr. KERLIKOWSKE. We do.

Mr. MICA. Okay, well again, maybe you can provide me with some update on it. I think that is very important, and social media, too, is I am finding out in the campaign, is very, very important, and a new way of getting to possible users and people affected by it.

And if you could share with us—I think this administration, this President, you need to be in the face of Mexico, and we if we need to go back and change the law, you give us the recommendations to update 2004, what other resources you need, and we will work with you. Thank you, Mr. Chairman.

Mr. GOWDY. Thank the gentleman from Florida. The chair will now recognize himself for 5 minutes of questions.

Let me start, Director, by thanking you for your previous service in law enforcement.

And I was having a hard time getting my little noggin wrapped around—in Judiciary, it is not uncommon to hear some of our colleagues call for the legalization of what would now be schedule I controlled substances. So to go from calling for the legalization, and I am not saying you have. I have never heard you say it, but the disconnect between calling for legalization of what are now schedule I controlled substances to the quasi-criminalization of what are now over-the-counter drugs just seems like something of an inconsistency to me. But perhaps it is just me.

Without waving my Fifth Amendment right against incrimination, I don't think you can make moonshine without sugar, can you?

Mr. KERLIKOWSKE. I will take your word for this.

Mr. GOWDY. You can't write demand notes without paper and pen. You can't make cocaine base without baking soda, and you have to have water for moonshine and baking soda—and crack cocaine, and there has never been any conversation about criminalizing any of the above.

So at what point do we say, yes, this is an integral part of making something that is illicit or wrong, but the inconvenience of criminalizing baking soda or water or pen and paper is just a bridge too far for us? We are going to concentrate on the 1 percent that is breaking the law, and not the 99 percent who do like they are supposed to do.

Mr. KERLIKOWSKE. I think—I mean, your points are excellent. I guess when I talk to my colleagues around the country who are in law enforcement, they are all suffering from reduced budgets. They have had layoffs. They have had reductions in force. They have had, in some cities, increases in violence. And going after people with fake IDs who bought too much pseudoephedrine over the counter is not going to be on their highest list of priorities. And that is a fact.

Mr. GOWDY. Well, I am not disagreeing with you, but I would wonder this: How many of the so-called smurfs have been prosecuted for conspiracy? Because it just strikes me that our entire criminal justice or penal system is set up to get people's attention with incarceration, and one way to get the smurf's attention, is to actually wrap them up and a Title 21 conspiracy count on the Federal side. Do you know how many of these so-called smurfs have actually been prosecuted for conspiracy?

Mr. KERLIKOWSKE. I don't know.

Mr. GOWDY. I want you to put your old hat back on for a second and see if my logic is flawed. If you decrease the demand or decrease access to ephedrine and pseudoephedrine, you could probably fashion an argument because you have seen addicts do things that are unspeakable in their quest for drugs. I have seen it. I just recalled a story about it.

What is to say that we won't have an increase in home invasions for addicts seeking ephedrine and pseudoephedrine from families that have a prescription for it in their quest to get it? Have there been any studies showing whether or not the criminal element has gone to—because they are very creative—gone to other routes to get these precursors?

Mr. KERLIKOWSKE. The only familiarity I have with the longer term on that is, again, Oregon, and in talking to law enforcement colleagues in that State, and I know you have a witness from the State of Oregon, regarding break-ins to homes to get the precursor chemicals for meth or stealing prescriptions for precursor chemicals for pseudoephedrine has not been an issue of concern to them. But I would take their testimony with their experience over, certainly, my anecdotal information.

Mr. GOWDY. Is there the prospect or possibility that Mexico's production will increase? If you accept that the demand for the product will remain the same without drug treatment, then what is to say Mexico won't meet that request for increased production if it decreases domestically? What is to say we won't see an even greater influx of methamphetamine from Mexico?

Mr. KERLIKOWSKE. I think as long as there is that demand here in this country, Mexico, those drug cartels, will do their very best to try and meet some of that demand. That is why I think the prevention information about the dangers of methamphetamine, and there are some incredibly, as you know, graphic demonstrations of advertising that seem to have made a difference in keeping people off methamphetamine. Again, that would be the far more important way to do this.

Mr. GOWDY. Well, my time is up. I will say this about drug treatment: We had a drug court in my home county, and the dirty little secret about drug court is it wasn't the prosecutors and it wasn't

the police officers who were opposed to it. It was the criminal defense attorneys, because drug court is much more difficult to survive under or on than simple probation. So some of my colleagues who are opposed to mandatory sentences in all forms may have to reconsider when it comes to drug court. Because if given the choice between probation, where you just wave your hand once every 6 months, and drug court, most defense attorneys opt for probation.

With that, you have a very difficult job, and we wish you great success. And we thank you for coming and testifying, and again, we thank you for your service in law enforcement as well as your service to our country.

Mr. KERLIKOWSKE. Thank you, Chairman.

Mr. GOWDY. We will stand at ease for a couple of minutes while the next panel comes forward.

[Recess.]

Mr. GOWDY. The committee will come to order. It is our pleasure to recognize and welcome the second panel of witnesses. I will introduce you from your right to left, my left to right. I will introduce you en banc and then recognize you each for your 5-minute opening statement.

Mr. Ron Brooks is the director of the Northern California High Intensity Drug Trafficking Area and the President of the National Narcotics Officers' Associations' Coalition.

Mr. Jason Grellner—and if I mispronounce anyone's name, correct me and forgive me—is a sergeant with the Franklin County Missouri Narcotics Enforcement Unit and the president of the Missouri Narcotics Officers Association.

Mr. Max Dorsey a lieutenant with the South Carolina Law Enforcement Division in the great State of South Carolina.

Mr. Rob Bovett is the district attorney for Lincoln County, Oregon, and the architect of Oregon's 2005 prescription-only law.

Mr. Marshall Fisher is the executive director of the State of Mississippi's, Mississippi Bureau of Narcotics and an architect of Mississippi's 2010 prescription-only law.

Again, pursuant to committee rules, and I always wanted to have Max Dorsey under oath so I could ask him some questions, and now I will have my chance.

Mr. GOWDY. So I would ask you if you will please stand and raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth and nothing but the truth.

Let the record reflect all of the witnesses answered in the affirmative.

Mr. Brooks, we will start with you and recognize you for your 5-minute opening statement.

STATEMENT OF RONALD BROOKS

Mr. BROOKS. I don't think this is working. Maybe you can hear me without it, because I think—okay.

Mr. Chairman, Ranking Member Davis, members of the subcommittee, thank you very much for holding this important hearing and for inviting me to represent the 68,000 members of the National Narcotics Officers' Associations' Coalition.

I am a 37-year law enforcement veteran, and I worked with methamphetamine investigations since 1980. I am currently the director of the Northern California High Intensity Drug Trafficking Area.

Every day, National Narcotic Officers' coalition members see firsthand the devastation, lost opportunities, violent crime, environmental destruction, and the death that meth use brings to our cities and towns. It robs children of their parents, young people of their dreams, and our country of the bright minds and sound bodies that we must rely upon to remain strong as a nation.

From the earliest days, it was clear that cutting off pseudoephedrine would virtually eliminate domestic meth manufacturing. When cooks could easily access pseudo at retail stores, we saw massive quantities purchased and converted to meth. As a result, the number of meth labs ballooned from 7,000 in 1999 to 18,000 in 2004.

We were inundated. It was truly an epidemic, and it was clear that we needed to make meth more difficult or needed to make it much more difficult for meth cookers to get their hands on pseudoephedrine. That is when the Congress focussed on the issue and passed the Combat Meth Act. One of the primary purposes of the Combat Meth Act was to restrict access by meth cooks to pseudoephedrine by requiring behind-the-counter products storage and recording of purchases in a logbook.

The facts tell a crystal clear story of what happens when we restrict pseudoephedrine. We went from 18,000 incidents in 2004 to 6,000 incidents in 2007, a drop of more than 65 percent, due in large part to the Combat Meth Act provisions to control pseudo.

But the CMEA's restrictions eventually led to innovation by meth cooks who resorted to smurfing, the practice of purchasing small quantities of pseudoephedrine products at several retail locations to bring back to a central manufacturing location.

We often see several people recruited to purchase a small number of packages and sell them to middle men who in turn sell the packages to the illicit cooks. After the initial steep Combat Meth Act decline, because of this smurfing technique, we saw a number of lab incidents increase again to 10,000 by 2011.

The law enforcement situation is much more challenging today because of layoffs and budget cuts. We are not equipped to deal with the surge in lab incidents the way we did in the 1990s. The COPS Meth Hot Spots Program used to provide critical support to our efforts, but Congress has cut its funding by 70 percent.

Unfortunately, the meth situation on the ground is alarming. Last year, 5,000 kilograms of meth were seized at the U.S./Mexico border, a 400 percent increase compared to 2008, and the domestic meth lab production numbers are certainly growing across the country.

There are really two clear lessons in history. The first is, controlling pseudoephedrine is the best way to prevent meth labs. The second, half measures to control retail pseudoephedrine will lead meth cooks to innovate workarounds to these obstacles.

The conclusion my members have drawn is that products containing pseudoephedrine should be accessible via prescription only on a nationwide basis. The fact is, making pseudo available only

by prescription significantly reduces the number of meth labs in communities.

My colleagues from Oregon and Mississippi will share clear evidence of the success of their prescription-only policies. We are talking about major declines in meth labs almost instantly from the passage of those laws. The policy works, and it should be embraced on a nationwide scale.

Some will say that tracking retail purposes of pseudoephedrine is the solution to the smurfing problem. While tracking has a positive impact in some areas, the impact is really limited, and it is not proven to reduce labs. Again, the facts tell the story. Kentucky was the first State to implement a tracking system. Every year since the implementation, the number of lab incidents in Kentucky has gone up. Tracking is reactive and very labor intensive. Relatively few agencies today have the resources to effectively track pseudoephedrine and make an impact, a true impact on their meth problem.

We are encouraged by the recent development of technology that has been shown to prevent pseudoephedrine from being extracted from pills, which means that illicit cooks could not use it to make meth. This would enable products containing pseudoephedrine to be sold in front of the counter. Consumer convenience and access to legitimate medicine would be enhanced, and meth lab incidents would decline. Those developments really should be encouraged and explored.

Mr. Chairman, we have a clear evidence of a policy that can save lives and protect communities. We really ought to act now before we lose control of this situation. On behalf of the dedicated men and women who respond to meth lab incidents every single day, the NNOAC strongly encourages Congress to study the Oregon and Mississippi examples and to pass a Federal law that makes pseudoephedrine products prescription only. And I want to thank you for your time. I am happy to answer questions.

[The prepared statement of Mr. Brooks follows:]

STATEMENT FOR THE RECORD

Ronald E. Brooks, President

National Narcotic Officers' Associations' Coalition (NNOAC)

Subcommittee on

Health Care, District of Columbia, Census and the National Archives

Committee on Oversight and Government Reform

United States House of Representatives

July 24, 2012

Chairman Gowdy, Ranking Member Davis, members of the subcommittee, thank you for inviting me to represent the 42 state, regional and national associations and 68,000 law enforcement officers represented by the National Narcotic Officers' Associations' Coalition (NNOAC) at this important hearing. Our members are the men and women on the front lines who have dealt with the very worst of the methamphetamine problem since the earliest days of the scourge, and we have played a role in policy efforts to reduce the problem since the early 1990s. We strongly commend you for convening this hearing today and appreciate the opportunity to illuminate a serious national problem – but also shine a spotlight on a clear national solution to that problem.

My name is Ron Brooks and I am the Director of the Northern California High Intensity Drug Trafficking Area (HIDTA). I retired in 2005 as Assistant Chief with the California Department of Justice Bureau of Narcotic Enforcement. I am a thirty-seven year law enforcement veteran with more than thirty years spent assigned to drug enforcement. I have been working the meth problem since the 1970s when we investigated labs as targets of opportunity

and disposed of the toxic waste in trash cans after processing the lab scene without the benefit of any specialized training or personal protective equipment. I have worked at the street level busting labs and the policy level here in Washington to control precursor access. I have lost law enforcement friends at incredibly early ages to cancers which doctors have suspected stemmed from years of exposure to chemicals found at meth labs that my friends busted. I have seen horrific sights at meth lab scenes in homes where young children are sleeping in the same room as the lab equipment and chemicals.

Methamphetamine and other drugs of abuse 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. Yet, every single day millions of children across our great nation are exposed to illicit drugs through friends, family and schoolmates. The pervasive availability of methamphetamine and other dangerous drugs will tempt to many children to make the 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 drummers traveling throughout the nation, resulting in per-capita drug addiction rates that rival the worst we have seen in recent times. But aggressive drug laws, beginning with the Harrison Act of 1914, and a strong public anti-drug message worked to control the threat. We have made tremendous progress in our fight against drug abuse and addiction – overall drug use rates are down more than 20% since 2000. But the threat continues, and today we are dealing with synthetic drugs such as methamphetamine manufactured in Mexican super labs that are spilling across our porous border in record amounts, as well as clandestine meth laboratories in communities across the nation.

Unfortunately, the widespread availability of methamphetamine and other addicting drugs poses as great a threat today as anytime in our nation's history. During my 37-year career I have personally witnessed every drug use trend including methamphetamine, crack cocaine, PCP and LSD that our nation has experienced. I seized my first meth lab in 1981 and since that time I have personally investigated hundreds meth labs and 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.

Dangers are posed by all drugs of abuse, but I have never seen a drug cause more devastation 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 were 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.

From the earliest days it was clear that meth was unlike many other illegal and dangerous drugs. Anybody could make it in their car, backyard, or kitchen, provided they had access to the right ingredients. You didn't have to transport it across any controlled border. It was an incredibly powerful, addicting, and long-lasting high, and it destroyed lives like we in law enforcement had never before seen. And unfortunately, despite the heroic efforts of America's law enforcement officers, we are still dealing with the horrors of meth.

From the earliest days, it has been clear that cutting off the necessary precursors would virtually eliminate the ability of cookers to manufacture meth. In the mid-1990s when I worked with the Bureau of Narcotic Enforcement in California, I came to Washington, DC and briefed Senator Dianne Feinstein, DEA Administrator Tom Constantine, and Drug Czar Barry McCaffrey about the growing problem of meth manufacturing in California. Like many states, we were seizing hundreds of smaller meth labs, but we were also seeing massive "super labs" operated by Mexico-based cartels that manufactured hundreds of pounds of meth in a single production cycle for distribution throughout the nation. During Operation Mountain Express and other large scale investigations, law enforcement discovered organized criminal groups – including a designated foreign terrorist organization – bringing in large quantities of raw precursors from outside the United States to supply cartel-operated super labs.

With as much as seven pounds of toxic waste being produced for every pound of finished methamphetamine, we were finding extensive environmental damage around labs and at sites

where lab waste was being dumped. Even more devastating was the plight of meth addicts, many who had been kids or young adults with bright futures, falling into the abyss of meth addiction, with little hope for recovery, heartbreakingly desperate for nothing else other than their next high. Most despicably, we saw young children subjected to toxic chemicals in filthy conditions and burned by lab explosions. Sen. Feinstein was alarmed from the first briefing. She went on to author precursor control legislation. But meth was so powerful – and so profitable – that cookers quickly devised ways to ensure access to the necessary ingredients. Lab incidents nationwide eventually increased to more than 7,000 in 1999.

By 2004, federal, state, and local law enforcement reported more than 18,000 lab incidents. While the definition of "lab incidents" at the time was interpreted differently depending on jurisdiction, more than 50 meth lab incidents *per day* were occurring in this country, and the number of states reporting a major meth lab problem had greatly increased. We were inundated – it was truly an "epidemic". Toxic waste was being discovered in local water sources. Maimed and burned people – including children – from meth lab explosions were becoming more common. Because of the unique requirements of responding to hazmat scenes – which each meth lab is – the seizure and dismantling of meth labs is extremely dangerous and resource-intensive. The ballooning cost was borne primarily by the responding state or local law enforcement agencies and the DEA contributed valuable assistance in the clean-up process. But we needed more help. Above all, we needed to make it much more difficult for meth cooks to access the most important ingredient: pseudoephedrine (PSE).

That is when Congress focused on the issue and passed the Combat Methamphetamine Epidemic Act of 2005 (CMEA). One of the primary purposes of the CMEA was to restrict access to pseudoephedrine and limit its availability to meth cooks. Massive quantities of popular cold remedies were being purchased at stores and converted directly to meth.

Statistics tell the story of what happens when we control precursors through strong federal laws: we went from over 18,000 incidents in 2004 to just over 6,000 incidents in 2007. 12,000 fewer incidents – a drop of more than 65% - in just three years due in large part to CMEA provisions restricting meth precursor availability.

We saw a substantial increase in labs after that initial steep decline, with more than 10,000 lab incidents reported in 2011. Our experience on the ground showed that this was mostly due to meth cooks resorting to "smurfing" – the practice of purchasing small quantities of pseudoephedrine products at many retail locations to bring back to a central manufacturing location. With behind-the-counter product storage and logbook requirements, meth cooks had to find other ways to access products containing pseudoephedrine. By recruiting several people to each purchase relatively small quantities of pseudoephedrine products from multiple retail locations, cooks could amass larger quantities for meth production. This is one of the main problems we are dealing with today.

Compounding our challenge, however, is the budget situation at the local, state, and federal levels. With recent layoffs and budget woes at our agencies nationwide, we are not equipped to deal with the new surge in lab incidents the way we did in the 1990s. My former agency, the California Bureau of Narcotic Enforcement (BNE), the nation's oldest drug law enforcement agency and a leader in meth lab investigation and enforcement, was recently abolished along with many of the fifty-five multi-jurisdictional drug task forces that BNE operated. In the late 1990s and 2000s BNE operated the California Methamphetamine Strategy (CALMS) with strong federal grant support through the COPS Meth Hot Spots program. At its high point, nine highly trained CA DOJ CALMS teams operated throughout California. But recent state and COPS Meth budget cuts have decimated our capacity, and funding remains for just one single CALMS team stationed in Fresno. The COPS Meth Hot Spots program has been cut 70% despite a clear need for federal support to states to investigate interstate and international meth production and trafficking organizations. Other city and county law enforcement agencies throughout California and across the nation have eliminated their drug enforcement teams as they struggle to fund enough law enforcement officers to answer 911 calls. In my HIDTA area we estimate that there has been at least a 70% reduction in officers assigned to investigate meth labs and other drug crimes. As the president of the NNOAC, I am hearing similar stories form colleagues around the nation. Yet the situation on the ground is alarming: in 2011, 5,035 kilograms of meth was seized at the US/Mexico border, a staggering 400% increase compared to 2008. This past March, agents seized 750 pounds of meth in San Jose, CA, with an estimated value of $34 million -- the largest seizure of meth in U.S. history.

So as we deal with a resurgence of domestic meth lab incidents, we are facing serious shortfalls in enforcement capacity. In addition to the COPS Meth Hot Spots cuts, Byrne JAG has been cut more than 30%, resulting in the elimination of multi-jurisdictional drug task forces across the nation. The Regional Information Sharing Systems (RISS) program, the backbone of law enforcement information sharing and analytical support to multi-jurisdictional drug investigations, has been cut 40%. Meth cooks and other drug traffickers love these facts – it means they can conduct their deadly business and perpetrate chemical attacks on America's neighborhoods with much more ease. Congress should remember the number one responsibility of government at every level is the protection of citizens, and should restore funding for Byrne JAG, RISS, and the HIDTA Program. The reduced capacity of law enforcement makes today's hearing topic – control of precursors – even more urgent.

There are two clear lessons from this history: 1) controlling pseudoephedrine is the best way to prevent meth labs; and 2) half-measures to control retail pseudoephedrine availability will lead meth cooks to innovate their way around obstacles.

The conclusion we have drawn is that products containing pseudoephedrine should be accessible via prescription only on a nationwide basis. The meth lab problem – independent of, but along with, the meth abuse and addiction nightmare – must be controlled. And the best way to do this while preventing relatively easy work-arounds is to make pseudoephedrine products available only by prescription.

We constantly hear messages from groups funded or influenced by certain pharmaceutical industry stakeholders who argue that controlling pseudoephedrine by making it prescription-only will not impact the production of methamphetamine. Fortunately, we have two examples of states whose pseudoephedrine control laws demonstrate how absolutely wrong those arguments are: Oregon and Mississippi. The lab incident numbers from those two states are very convincing: Oregon reported nearly 500 incidents in 2004, and only 21 in 2007 after the statewide prescription-only law took effect in 2005. Mississippi reported nearly 700 incidents in 2009, and only 259 in 2011 after the statewide prescription-only law took effect in 2010.

Facts are facts: making pseudoephedrine available only by prescription significantly reduces the number of meth labs in our communities.

This means significantly less meth available to tempt and poison our children, dramatic reductions in the amount of meth lab-related toxic waste to contaminate our communities, fewer meth-intoxicated drivers on our roadways and far fewer kids exposed to dangerous meth lab chemicals. The answer is clear. If we want to protect our kids and keep our communities safe, pseudoephedrine must be controlled nationwide through a federal prescription-only law.

I want to address the issue of tracking pseudoephedrine retail purchases because we hear a lot about it, and many of our states have implemented tracking systems. Tracking is often presented to policy makers by some pharmaceutical and retail industry groups and the public as a solution to the "smurfing" problem. The NNOAC believes that while tracking may make sense in theory, it has not proven to be a solution to the meth lab problem. The facts tell the story: Kentucky was the first state to implement a tracking system. Every year since the implementation, the number of lab incidents in Kentucky has gone up. Tracking is clearly not the answer. Tracking is a reactive meth investigation technique that is labor-intensive. In today's budget environment relatively few agencies have the law enforcement resources to effectively use tracking to impact the meth problem. And while tracking is reactive at best, control of pseudoephedrine through prescription-only laws is *true* prevention, a solution to save lives while having the least impact on public budgets.

Facts also tell us that there are so many people smurfing that we cannot arrest our way out of the problem. NNOAC members report that a typical smurfing investigation requires two uniformed officers and four detectives, with roughly an eight-hour detail for each of those six officers. The typical result of the investigation is two or three smurfers arrested, and possibly a meth lab discovery. In some areas these investigations are leading to fewer meth lab discoveries because our members have found that cooks are putting a broker between themselves and the smurfers to isolate and protect the lab operations.

The evidence shows that just tracking retail pseudoephedrine purchases is at best a band-aid solution and is clearly not the best answer to this very serious public safety and public health problem. Even when budgets were larger and more law enforcement resources were available, tracking was never as effective as true precursor control, and that is why the NNOAC strongly supports a national prescription-only approach to controlling pseudoephedrine based upon the programs that Oregon and Mississippi have implemented with unquestionable success.

I want to be clear that the NNOAC does not believe that making pseudoephedrine products prescription-only will solve the methamphetamine abuse problem in America. The full range of prevention, education, treatment, and enforcement programs must be applied. But it would go a long way toward eliminating the horrors of the domestic lab problem in America.

We know that the following six things happen when you reduce meth labs. You:

- make communities safer,
- prevent children from being exposed to dangerous chemicals and lab explosions,
- help prevent meth use initiation and addiction,
- improve the safety of law enforcement officers and other first responders,
- prevent toxic chemicals from being dumped in neighborhoods and polluting the water table, and
- conserve scarce resources for budget-strapped state and local governments that have to foot the bill for lab clean-up.

We often hear opponents of a prescription-only policy cite consumer access and convenience issues as a problem. I want to be clear that our purpose is not to make it difficult for patients in need of medicine to obtain pseudoephedrine products. If a person needs the product for legitimate purposes, they should be able to obtain it. The Oregon and Mississippi examples offer evidence that consumer access is not the problem it is made out to be by some in the pharmaceutical retail industry.

Regarding consumer convenience under a prescription-only pseudoephedrine policy, we are aware of a very promising technology innovation that would enable products containing pseudoephedrine to be sold in front of the counter. Technology that prevents pseudoephedrine from being extracted from pills has been shown to prevent the manufacture of meth from those pills using known illicit production methods. This technology would offer relief to legitimate sufferers while offering no value to meth cooks, and would be made available in front of the counter – just like Tylenol or Advil. Consumer convenience and access would be enhanced, and meth lab incidents would likely decline. We hope this technology can be made available to the public as soon as possible.

In 2006, I attended the Vigil for Lost Promise, an event sponsored by DEA and the parents of six children who had died as the result of drug overdoses. This moving event focused 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 to 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. When we have incontrovertible evidence staring us in the face that can save lives and protect communities, we ought to act. We hope this committee and Congress will act accordingly.

Within the past three years I have comforted two close friends – law enforcement partners of mine – as they died from cancer that resulted from their years of exposure to toxic chemicals at the meth labs they 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.

On behalf of the dedicated men and women who respond to meth lab incidents, rescue children from terrifying scenes, and deal on a personal level with the effects of meth labs every day, the NNOAC strongly encourages Congress to study the Oregon and Mississippi examples and pass a federal law that makes pseudoephedrine products prescription-only.

I appreciate the opportunity to provide the NNOAC's perspective on this critical issue. We commend the subcommittee for holding this hearing, and we look forward to continuing our work with Congress to advance policies that hit at the core of the domestic meth lab problem.

Mr. GOWDY. Thank you, Mr. Brooks.
Mr. Grellner.

STATEMENT OF JASON GRELLNER

Mr. GRELLNER. Yes, sir. Mr. Chairman, Ranking Member Davis, members of the subcommittee, thank you for providing me the opportunity to testify before you today.

I am Detective Sergeant Jason Grellner. I am a task force commander of a unit in Franklin County, Missouri, just outside of St. Louis. I am also president of the Missouri Narcotics Officers Association, and I am here representing the 350 members who struggle daily to fight methamphetamine laboratories.

Missouri has consistently led the nation for more than a decade in clandestine methamphetamine laboratories reporting over 27,000 found meth lab incidents since 1994. My task force has federally indicted 50 people for smurfing and manufacturing meth in just the first 6 months of this year, and we usually annually indict 50 people.

During my 21-year career in law enforcement, I have led investigations of over 1,600 meth labs in Franklin County. My unit investigates a lab incident on average, once every 3 days. I have often seen throughout my career the rippling effects the clandestine methamphetamine laboratories have on the elderly addicts' families, innocent children, and the public at large.

Approximately 50 children a year in Franklin County are removed from meth lab homes and placed into State custody. Over the past 15 years, I have earned the name bogeyman, given the number of times that I have taken children away from their family due to methamphetamine labs.

The business of methamphetamine lab production is both painful and costly. At nearby Mercy Hospital Burn Unit in St. Louis, the director is quoted as saying that on any given day at least 15 to 25 percent of their burn unit beds are occupied by uninsured meth lab burn victims at a cost of over $6,000 per day.

In June of 2002, well into my 26th consecutive hour of work, I made the mistake by opening a container that contained anhydrous ammonia, an ingredient in the manufacture of methamphetamine. This poisonous gas caused immediate burning to my eyes, nose, mouth, throat, and lungs, and later a blistering of my mouth and throat. I was eventually diagnosed with lung disease, where it was found that I lost 25 percent of my lung capacity.

In the last 6 months, five of my six investigators have been hospitalized for cancer, kidney transplant, and unknown tumor growing in their chest because of methamphetamine laboratories that they have investigated.

As I look back over a lengthy career, I know that 80 percent or more of all crime revolves around drug and alcohol addiction. For this reason, the Franklin County Narcotics Enforcement Unit is built on the principles of prevention, enforcement, and rehabilitation. Our offices are home to three prevention specialists and seven narcotics investigators who are members of a local drug CORE team. At our facility, we host counseling service and pay for housing of participants in the drug CORE program.

We have our own 501(c)(3) foundation helping to build a strong community coalition to prevent addiction before it starts. We understand that law enforcement, substance abuse prevention, and rehabilitation must work together in order to have a long-lasting effect on narcotics crimes and addiction.

I know the growth of meth labs is a direct result of the decision made by the United States Food & Drug Administration in 1976, when the agency faced a decision as to whether or not pseudoephedrine hydrochloride should be an over-the-counter drug. By allowing pseudoephedrine to become OTC, I know the face of narcotics law enforcement in this country changed.

Now what we are faced with more recently is a new black market of pseudoephedrine that has transformed this product from a commodity to currency. We commonly now see heroin addicts and those addicted to prescription pain relievers using boxes of cold tablets containing pseudoephedrine in trade for their narcotics of choice. A box of pseudoephedrine in Southern Illinois and St. Louis now sells for $100 a box.

Criminals now go to the pharmacy not to receive beneficial medication but to exchange currency.

In 2009, I began a campaign asking local cities and counties to enact ordinances requiring a prescription for pseudoephedrine. Washington, Missouri, enacted its ordinance on July of 2009. In the 90 days prior to the ordinance, five pharmacies in Washington sold 4,346 boxes of cold tablets. In the 90 days following the enactment of this ordinance, those same pharmacies saw a 94 percent drop in sales, and only sold 268 boxes. Inspecting sales records at pharmacies surrounding Washington during the same time period saw no rise in sales after the implementation of the ordinance. This city also experienced an 85 percent decrease in meth-related calls for service by the police.

Tracking databases, which track the sale of PSE in real time, do nothing to halt the spread of methamphetamine labs. Missouri in 2011 alone tracked 1.76 million sales. Missouri sells one box of pseudoephedrine every 17 seconds. The State experienced a 6.8 percent increase in meth labs between 2010 and 2011. In the southeast portion of the State, where nearly 70 cities now require a prescription for pseudoephedrine, we saw a 52 percent drop in methamphetamine labs. And I see I am out of time.

[The prepared statement of Mr. Grellner follows:]

Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence

Testimony Submitted by Detective Sgt. Jason Grellner,

Task Force Commander, Franklin County Narcotics Enforcement Unit

July 24, 2012

House Committee on Oversight and Reform

Subcommittee on Healthcare, District of Columbia, Census and the National Archives

2203 Rayburn House Office Building

Rep. Trey Gowdy, Chairman

Rep. Danny Davis, Ranking Member

Chairman Gowdy, Ranking Member Davis, Members of the Subcommittee, thank you for having me here today and thank you for your interest in this very important matter. My name is Jason Grellner, I am the task force commander of the Franklin County Narcotics Enforcement Unit located in Franklin County, Missouri near Metropolitan St. Louis. Franklin County is a diverse community, with just over 100,000 residents living on rural farms and in luxury homes. I am also the president of Missouri Narcotics Officers Association and I am here today representing the 350 members of our organization who struggle on a daily basis to fight methamphetamine laboratories throughout Missouri.

Missouri has consistently led the nation for more than a decade in clandestine methamphetamine laboratories and has recorded over 27,000 meth lab incidents since 1994. My 21 year commitment to law enforcement has led to my investigation of over 1,600 of these meth labs throughout Franklin County and has shortened my life and the lives of many of my colleagues.

My understanding of the effects of drug abuse on society began at an early age. As a high school freshman I became involved in numerous prevention programs including; SADD-Students Against Drunk Driving, RTI-regional teen institutes and a founding member of TREND a group dedicated to hosting recreational activities for teens that are drug and alcohol free. I continued my involvement in these organizations and activities throughout my high school and college career. As a youth I learned the importance of living a healthy lifestyle and the harmful effects of the disease of addiction. This foundation strengthened my resolve as I began my career in law enforcement and has been a guiding principle for the past 21 years.

As a young patrol officer, it was apparent that the vast majority of individuals involved in criminal activity were impacted by the disease of addiction. As I look back over a lengthy career, I truly believe that 80% or more of all crime revolves around drug and alcohol addiction.

For this reason, the Franklin County Narcotics Enforcement Unit is built on the principals of: prevention, enforcement, rehabilitation. Our offices are home to three prevention specialists and seven narcotics investigators. In addition, we are members of the local drug court team. At our facility, we host counseling services, AA and NA meetings, and we pay for housing of participants in the drug court program. Our unit supports scholarships for children in the local middle and high schools to participate in drug and alcohol free leadership programs, and we offer community education programs on drug abuse and awareness. We now have our own 501(c)(3), Foundations for Franklin County, which is helping to build a strong community coalition to combat the disease of addiction. We truly understand that law enforcement, substance abuse prevention and rehabilitation must work together in order to have a long lasting effect on narcotics crimes and addiction.

In 1996, I began investigating narcotics crimes in Franklin County Missouri as a way to have an immediate and dramatic effect on all crime in my community. In a very short period of time, the clandestine manufacture of methamphetamine consumed all of my days. I officially worked my first clandestine methamphetamine laboratory on December 13, 1997 and have watched as it has devastated the community that I swore to protect and serve. I am the father of two children and I pray each day that they are not harmed innocently by activities that are ultimately driven by the disease of addiction.

I have often seen throughout my career the rippling effects that clandestine methamphetamine laboratories have on innocent children, the elderly, addict's families and the public at large. At this point, the task force under my command investigates a clandestine lab incident on average, once every three days and that ratio has stayed steady for the last four years.

In June of 2002, while working the third meth lab of the day, well into my 26th consecutive hour of work, I made a mistake: I opened a container that held what I believed to be a rather harmless chemical used to manufacture methamphetamine. To my surprise, it contained anhydrous ammonia, a poisonous gas that caused immediate burning in my eyes, nose, mouth, throat, and lungs. I experienced blistering in my mouth and throat shortly after the chemical exposure and it was necessary for me to seek medical attention. Shortly after the acute effects of exposure began to wear off, I began to notice problems with my breathing. The breathing problems made it hard for me to wear my air purifying respirator, and my self-contained breathing apparatus. After numerous doctor visits and medical tests, I was diagnosed with lung disease as my medical team found that I lost twenty five percent of my lung capacity. These medical findings have only strengthened my resolve to eradicate my community of these dangerous meth labs.

I believe there is a solution to address the fight against clandestine meth labs. In 1976, the United States Food and Drug Administration (FDA) faced a decision as to whether or not pseudoephedrine hydrochloride should be made an over-the-counter (OTC) drug. By allowing pseudoephedrine to become OTC, I believe the face of narcotics law enforcement in this country was changed. By the early 1980's, clandestine meth labs using recipes that reduced pseudoephedrine hydrochloride into methamphetamine hydrochloride were being located in the southwestern United States. Ten years later,

labs were being located in the Midwestern United States. By 1996, they were located in the metropolitan St. Louis area. In a period of only two decades, the United States had gone from almost no clandestine meth lab reports to clandestine lab reports that spanned from the Pacific Ocean to the Mississippi River. Now, they are reported in almost every state in the union.

Generally, in law enforcement, it is extremely difficult to completely eradicate a crime because of free will. From time to time, sometimes unexplainably, citizens will violate criminal law. In the case of clandestine methamphetamine laboratories, however, we have the chance to remove the ability for someone to break the law. By reversing the actions of the FDA in 1976, we can turn back the clock in this country to a time when were not plagued with meth labs.

The problem is the close chemical make up of pseudoephedrine and methamphetamine. The difference between Pseudoephedrine (PSE) and D-Methamphetamine is one oxygen atom. By removing that one oxygen atom, a nasal decongestant is converted into one of the most addictive drug currently known, d-methamphetamine.

The discussion about the classification of pseudoephedrine hydrochloride often generates debate. For example, some believe that other chemicals will be used to make methamphetamine if pseudoephedrine hydrochloride is reclassified. They are wrong. There isn't anything else that can be as easily converted into methamphetamine.

PSE was approved by the FDA for the treatment of sinus congestion for 4 to 12 hours per product directions by decreasing inflammation in the sinus cavities and ear canal. The FDA recommends that

individuals discontinue use of these medications if symptoms persist longer than five to seven days. This warning also advises consultation with a physician prior to any further use. PSE treats a symptom for a very short period of time, while methamphetamine labs have devastated our communities, my state of Missouri, and our nation for over two decades.

I often pose the question: if we could convert any other OTC product into heroin or cocaine, would we allow it to be sold? If law enforcement was locating 14,000 opium fields or cocoa plantations each year in United States, would we stand for that? Yet each year, law enforcement across the country reports thousands of pseudoephedrine based clandestine methamphetamine labs.

Clandestine methamphetamine laboratory production in the United States is a crime linked to addiction. This is in direct conflict with most other narcotics crimes. Most of the narcotics industry, like most other legitimate businesses, is driven by money and profit. Clandestine methamphetamine laboratories however, are driven by the addicts' ability to manufacture the drug they so desperately need. Clandestine lab operators manufacture just enough methamphetamine to consume – and enough to sell – in order to make enough money to buy the ingredients for the next meth lab. This cycle continues as many as three times a day and money is of little importance to the addict. There are no drug kingpins in the world of meth lab manufacturing -- only desperate addicts who can not find a way to break the cycle of addiction.

In my jurisdiction, I am known by many names, some pleasant and some that cannot be repeated in mixed company. The one that I reflect upon most frequently is Boogie Man. Over the past 15 years, I have taken more children from families than childhood disease. On average, 50 children a year are

removed from meth lab homes and placed into state custody in Franklin County. Methamphetamine addicted parents become so involved in their own addiction that they neglect everything else in their lives. Different than alcoholics or cocaine or heroin addicts however, they not only neglect their children, these parents manufacture their drug of choice, under extremely dangerous conditions. They make or "cook" this horrible drug in the same homes and rooms were they should be caring for their children. The disease of addiction impairs their judgment to the point that it becomes normal to manufacture methamphetamine in their homes -- subjecting their children to poisonous gases, corrosive liquids, flammable solvents, and explosive mixtures. These children are growing up in hazardous waste sites and are being socialized to believe that this is how everyone else lives. Their young bodies, still growing, are susceptible to numerous diseases as they are constantly subjected to this toxic chemical environment. So many children have been removed from their homes that Franklin County no longer has available foster families to care for them. The Division of Family Service workers scour the area trying to locate family members that are clean of addiction and crime who can care for these children.

In December of 2010, the Missouri Division of Family Services made our unit aware that they were running low on the most basic of needs: diapers, infant formula, coats, clothing, and school supplies. My unit rallied around these children and, with the help of the public, raising over $11,000 and received a tractor-trailer load of clothing and other supplies for these kids.

Currently, detectives from my unit are investigating the death of an infant who was subjected to meth manufacturing. The parents in this case have already each had a child removed by the state. Two of their previous residences had caught fire and burned. The mother has admitted to intravenous methamphetamine use and both parents were suspects in numerous methamphetamine crimes. The walls

of the home tested positive for methamphetamine and investigators have interviewed numerous suspects who were involved in manufacturing methamphetamine with the parents. A month after the death the child, the trailer home where the child died burned to the ground. A meth lab is suspected as the cause of this fire also. I have lost count of the number of children that I have placed into the back of patrol vehicles, ambulances, sat with in emergency rooms as they were decontaminated and treated by physicians.

Young children are not the only ones impacted by the manufacturing of methamphetamine. In November of 2009, as a college student lay sleeping in his apartment bed, his neighbors began the process of manufacturing methamphetamine just down the hall. While attempting to extract the pseudoephedrine hydrochloride from the cold tablets, a fire erupted in their bed room and they could not control it. One of them fled to safety through the front door of the apartment and the other out of a second-story window. Neither took the time to awaken or warn the other residents of the building. The 20-year-old college student lost his life -- burned to death in his bed. The building was destroyed by the blaze. This apartment building was directly across the street from the local sheriff's department and county courthouse. Both suspects were later caught and the female was pregnant at the time of her arrest.

The manufacture of methamphetamine infringes on so many individual rights it would be hard to list them all. I think the most important right to keep in mind is the right of a child to grow up in a safe home. Approximately 1,100 children were located dead, injured or living in a methamphetamine lab in the United States in 2007. Who wouldn't walk around with a stuffy nose if it meant saving the life of a child? Other rights to consider are:

- The right of farmers not to have to worry about people coming onto their property to steal anhydrous ammonia from nurse tanks and poisoning their families.
- The rights of fishermen and hunters to not find methamphetamine labs and hazardous waste on their hunting grounds and in their lakes and streams.
- The rights of campers and hikers not to confront these same issues in state and national parks.
- The rights of property owners to not have hazardous materials dumped on their properties.
- The right to purchase a new home and not wonder whether methamphetamine was ever manufactured there and whether this will cause health problems for your family.
- The right to rent a hotel or motel room and not wonder whether methamphetamine had been made there the night before
- The rights to drive safely down any road without fear that a passing vehicle will burst into flames and crash into your vehicle.
- The right to sleep soundly without the fear that your neighbor's apartment will catch fire from a methamphetamine lab or explode and kill you in your sleep.

The answer to the devastating problem seems to be so simple, the mere control of pseudoephedrine as it was 35 years ago.

In a 2007 RAND study, it was estimated that conservatively, methamphetamine had cost US taxpayers $23.4 billion dollars in 2005 alone. An Oklahoma study done in 2004 found that, on average, a

methamphetamine lab investigation, ending in a conviction, cost their state approximately $350,000 each.

There is a new pseudoephedrine black-market that has transformed pseudoephedrine from a commodity to a currency, impacting more of the narcotics market than just methamphetamine. We now commonly see heroin addicts and those addicted to prescription pain relievers using boxes of cold tablets containing pseudoephedrine in trade for their narcotic of choice. We recently worked investigation where numerous inner-city gang members were standing on the parking lots of Walgreens stores in the Metropolitan St. Louis area, offering anyone going inside, $10 extra to purchase a box of cold tablets for them. One gang member would later collect all of the boxes purchased and offer them for sale to multiple methamphetamine cooks in least three Missouri counties. He would auction these boxes off to methamphetamine "cooks" taking no less than $65 per box. After his arrest, the gang members who had collected the pills, commonly referred to as a pill broker, admitted that in 24 months time he had moved over 10,000 boxes of cold tablets from the city of St. Louis to meth labs in rural areas.

Currently our unit is working a case where individuals are now purchasing boxes for $100 and are being supplied with as many as 75 boxes each night. These boxes are once again being supplied by inner-city gang members. These gangs are then able to reinvest the profits, made on the sale of cold tablets, into their heroin trade. Heroin addicts commonly confess that if they have $10 they have a choice between purchasing one dose of heroin or one box of cold tablets. If they purchase the cold tablets and sell them to meth lab operator they can buy more heroin. None of this is stopped by the tracking database and there is no way to track all of the seemingly innocent people who are purchasing pseudoephedrine and handing it off to individuals standing on the parking lots of large chain pharmacies.

I believe the current tracking database has also caused methamphetamine producers to change the method by which they produce methamphetamine. Purchase restrictions lowering the daily and monthly amount of pseudoephedrine which can be legally obtained have shrunk meth labs to the size of water bottles. This new "one pot" or "shake and bake" method of manufacturing methamphetamine, although smaller in size, is tremendously more dangerous than its predecessor. The amount of pseudoephedrine necessary for this new recipe is quite small and therefore yields only a small amount of methamphetamine. This forces methamphetamine addicts to repeat the process more often. The combining of multiple chemical reactions in bottles ranging from 2 Ltr. soda bottles to 20 ounce water containers are extremely explosive. The small size of these reaction vessels makes them easy to conceal and very mobile. These labs are so mobile that the Walmart Corporation has been the victim of meth manufacturing in three of its stores, including Kansas, Alabama and last month Missouri. In each of these cases, individuals were manufacturing methamphetamine while walking through the store buying and shoplifting the necessary ingredients.

Multiple fires and explosions have resulted from this manufacturing process in homes, apartments, hotels and moving vehicles. The director at Mercy Hospital burn unit in St. Louis is quoted as saying that on any given day at least 15% to 25% of their burn unit beds are occupied by uninsured, meth lab burn victims at a cost of over $6,000.00 a day. In 2010, the Vanderbilt University burn unit reported that they had spent over $9 million of hospital resources on uninsured meth lab burn victims. Our unit alone has seen nearly a dozen vehicles which have burned after the occupants of the vehicles were attempting to manufacture methamphetamine while driving. These fires burn so intensely they rarely leave evidence necessary for prosecution.

In 2009, I began a grassroots campaign asking local cities and counties in Missouri to enact ordinances requiring a prescription for pseudoephedrine. The first city, Washington, Missouri, enacted its ordinance in July of 2009. In the 90 days prior to the ordinance going into effect, five pharmacies in Washington Missouri sold 4,346 boxes of cold tablets. In the 90 days following the enactment of the ordinance, those same pharmacies experienced a 94% drop in sales and only sold 268 boxes. Inspecting sales records at pharmacies surrounding Washington, Missouri, during the same time period saw no rise in sales after the implementation of the ordinance. This city also experienced an 85% decrease in meth lab related calls for service to police. Since the success of this first ordinance, seventy of the other Missouri communities have enacted ordinances requiring a prescription for pseudoephedrine. The largest number of the cities and counties are located in a 12 county area in southeast Missouri. In 2011, this 12 county area saw a 52% drop in clandestine methamphetamine lab incidents while the state of Missouri as a whole experienced a 6.8% increase in lab incidents.

Recently, I began comparing the sales of pseudoephedrine in Missouri which is experiencing over 2000 meth labs a year to the state of Oregon which has required a prescription for pseudoephedrine since 2006. Oregon, a state of 3.8 million people routinely sells on average 9752 boxes of cold tablets each month while requiring a prescription. Missouri, a state of nearly 6,000,000 people should then by comparison cell roughly 15,400 boxes a month. Average sales of pseudoephedrine based cold tablets for 2011 were 144,000 boxes per month in Missouri. In June of 2012 the state of Missouri sold over 120,000 boxes in 30 days, this drop is believed to be due to the number of cities and counties now requiring a prescription. This simple comparison seems to up hold the findings of the Washington Missouri study, concluding that 90% or more of the pseudoephedrine-based cold tablets being sold today are being diverted to methamphetamine laboratories.

We know any approach to addressing our nation's drug problem, including the use and abuse of methamphetamine must include prevention, treatment, and recovery.

As a result, before ending, I would like to mention that a critical partner in any successful strategy related to methamphetamine includes working with each State's Substance Abuse Agency Director. These State Directors manage the publicly funded treatment, prevention and recovery system. Their job is to plan, implement and evaluate a statewide comprehensive system of clinically appropriate care.

Every day, State directors work with a number of public and private stakeholders given the fact that addiction impacts everything from education, housing, employment and yes, criminal justice.

At the federal level, one action item the Committee can take is provide strong support for the *Substance Abuse Prevention and Treatment (SAPT) Block Grant,* which is the foundation of our publicly funded substance abuse prevention, treatment, and recovery system. An investment in the SAPT Block Grant ensures that resources reach all States and territories in an effective, efficient manner.

The SAPT Block Grant is vital to the state of Missouri. The state uses those funds to both prevent methamphetamine use and to treat people with methamphetamine addiction. Just two quick examples:

1) SAPT Block Grant *prevention* dollars support community coalitions all across the state that have worked to educate retailers about materials used to make methamphetamine and better identify individuals who are purchasing materials. Targeted prevention services are also provided through the Missouri Alliance of Boys and Girls Clubs, consisting of 13 Boys and Girls Club sites

throughout the state, which includes SMART MOVES and Meth SMART to over 60,000 youth ages 5-18 annually.

2) SAPT Block Grant *treatment* dollars fund effective substance abuse treatment—and treatment does work. In 2011, individuals receiving services from SAPT Block Grant funded programs demonstrated high abstinence rates at discharge from both illegal drug (74 percent) and alcohol (78 percent) use and 92 percent reported no involvement in the criminal justice system.

In addition, the *Partnerships for Success* program, which is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a tool States and territories can use to reduce substance abuse by addressing gaps in their current prevention services and enabling them to reach out to specific populations.

Another action item the Committee can take is providing strong support for programs within the Department of Justice (DOJ), including the Byrne/JAG program. This program, among other initiatives, helps support investigative Task Forces that help address methamphetamine abuse.

Thank you for your service to our country, and your attention to this matter.

Respectfully,

Detective Sgt. Jason J Grellner

Unit Commander - Franklin County Narcotics Enforcement Unit, President, Missouri Narcotics Officers Association

Mr. GOWDY. Thank you, Mr. Grellner.

Agent Dorsey.

STATEMENT OF DONALD "MAX" DORSEY, II

Mr. DORSEY. Chairman Gowdy, Ranking Member Davis, committee members.

My name is Max Dorsey, and I serve as a lieutenant with the South Carolina Law Enforcement Division, commonly known as SLED. I am currently a supervisory special agent in the narcotics unit, and I am also my agency's clandestine laboratory coordinator, responsible for directing matters related to the enforcement of South Carolina's efforts to stop manufacturing of illegal narcotics. Thank you for the opportunity for me to participate in this committee today.

South Carolina is experiencing a meth lab epidemic that is severely impacting law enforcement's resources and jeopardizing the welfare of our citizens. Despite both State and Federal efforts to prevent domestic methamphetamine production, meth labs in South Carolina continue to rise at an alarming rate.

As you know, meth labs are very dangerous. Entering a meth lab site is one of the most dangerous acts a law enforcement officer can do. Yet as labs become more numerous in our State, we find more innocent people harmfully exposed. For example, in May of this year, a horrific fire occurred in the Pine Harbor apartment complex in Goose Creek, South Carolina, killing three people. The victims of this tragedy were 4-year-old Samuel Garbe, 19-year-old Morgan Abernathy, and 69-year-old retired Air Force captain and Vietnam veteran Joseph Raeth. These people did nothing wrong. They were victims of circumstance. Their circumstance was that they were in their apartment in close proximity to a meth lab.

Although the manufacturing of meth cannot be exclusively proven to be the cause of the fire, it appears, based upon information present at the scene, that it most certainly may have contributed to the spread of the fire. During this manufacturing process, something went wrong and a fire ensued, causing the destruction of 16 units in the complex and the death of three innocent victims.

Over the past decade, several States and Congress have passed legislation in an attempt to combat the meth lab epidemic. Most of this legislation has sought to control access to meth's main ingredient, ephedrine and pseudoephedrine, which are also the main ingredients in cold medicines.

In 2005, Congress passed the Combat Methamphetamine Epidemic Act, which sought to limit daily purchases of ephedrine and pseudoephedrine-based products, thus restricting the amount of this necessary meth precursor chemical in the marketplace being diverted for the domestic manufacturing of methamphetamine.

The pharmaceutical industry supports tracking precursor chemicals and brought forward a potential solution known as the NPLEx system. The intent of NPLEx was to better electronically track ephedrine and pseudoephedrine purchases through a central interlinking database.

Despite the good intentions of NPLEx, it has not stopped domestic meth manufacturing in South Carolina. NPLEx is not limiting illicit purchases. In fact, in our first year of utilizing NPLEx, South

Carolina actually saw an increase in discovered labs. Any legislation that seeks to merely lower the purchase limit or track purchases does not effectively combat domestic meth production. It is too easy for criminals to subvert the CMEA and NPLEx through the practice of smurfing. These criminals simply steal identities or use fake I.D.'s to make their purchases. Neither CMEA nor NPLEx has done anything to reduce the number of meth labs in South Carolina.

In response to the growing meth crisis, Oregon and Mississippi passed new laws to prevent ephedrine and pseudoephedrine from entering the criminal marketplace by requiring a prescription to purchase ephedrine and pseudoephedrine-based products. The results of Oregon's and Mississippi's legislation have proven to be the most effective approach to combating domestic meth production within those States.

If we are serious about combating domestic meth production, Congress must pass legislation returning ephedrine and pseudoephedrine to prescription only. We have seen the absolute success of this approach in Oregon and Mississippi, as meth manufacturing has plummeted in those States.

President Ronald Reagan once said to sit back hoping that some day, some way, someone will make things right is to go on feeding the crocodile, hoping he will eat you last, but eat you he will.

Committee members, the crocodile is alive and well and is preying not just on our criminal justice system but our environment, our health care system, our social welfare system, and our economy. The committee has an opportunity to put the crocodile back in its cage and stop the domestic meth lab production in this country by rescheduling ephedrine and pseudoephedrine.

Thank you for your time, and I will be happy to answer any questions you may have of me.

[The prepared statement of Mr. Dorsey follows:]

STATEMENT OF

DONALD (MAX) DORSEY, II

OF THE

SOUTH CAROLINA LAW ENFORCEMENT DIVISION (SLED)

BEFORE THE
SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF COLUMBIA, CENSUS & THE NATIONAL ARCHIVES

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

UNITED STATES HOUSE OF REPRESENTATIVES

112th CONGRESS OF THE
UNITED STATES OF AMERICA

JULY 24, 2012

Introduction

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee:

By way of introduction, my name is Max Dorsey and I serve as a Lieutenant with the South Carolina Law Enforcement Division ("SLED"). SLED is the State's investigative authority with specific and exclusive jurisdiction over various functions and activities within the Palmetto State. Over the past 17 years, I have worked with SLED in several capacities, most of which have been focused on narcotic investigations. I am currently a Supervisory Special Agent in the Narcotics Unit and I am also SLED's Clandestine Laboratory Coordinator responsible for directing matters related to the enforcement of South Carolina's efforts to stop the manufacturing of illegal narcotics.

Thank you for giving me the opportunity to participate in today's hearing. My testimony will discuss how domestic methamphetamine production is impacting South Carolina and offer a solution as to how Congressional action can help law enforcement agencies across the country curtail the domestic production of methamphetamine.

Background

Although South Carolina has dealt with methamphetamine trafficking for decades and users lives have been ruined due to the drug's destructive nature, we have recently discovered the meth "manufacturing" epidemic has now reached our State. In 2007, SLED began receiving more frequent calls from Sheriff's offices and police departments regarding small scale meth manufacturing labs. These labs, commonly referred to as One-Pot labs, were typically capable of producing a few grams of meth. The labs were very small in size and were contained in plastic bottles, usually one to two liter drink bottles. Unfortunately, I report to you today that South Carolina is grappling with this meth lab epidemic in ways which we never could have imagined.

These domestic meth labs are treacherous and are increasing in frequency in a mind-boggling manner. The social, economic, health, environmental, and financial well-being of our communities is being negatively impacted due to this rampant increase in domestic meth manufacturing.

Methamphetamine, commonly known as "meth," is a highly addictive stimulant affecting the central nervous system. Although most of the methamphetamine used in this country comes from foreign or domestic super-labs, the drug is also easily made in small clandestine laboratories, with relatively inexpensive over-the-counter ingredients. These factors combine to make methamphetamine a drug with high potential for widespread abuse.[1]

Most chemicals used to produce methamphetamine are extremely hazardous. Some of these elements are highly volatile and may ignite or explode if mixed or stored improperly. Fire and explosion pose risks not only to the individuals producing the drug but also to anyone in the surrounding area, including children, neighbors, and emergency responders. Methamphetamine production is dangerous, even if a fire or explosion does not occur. Exposure to the toxic chemicals used to produce methamphetamine poses a variety of health risks including serious respiratory problems, severe burns, and damage to internal organs. Furthermore, methamphetamine production threatens the environment. The average methamphetamine laboratory produces five to seven pounds of toxic waste for each pound of manufactured methamphetamine. Methamphetamine manufacturers often dispose of this waste improperly, causing contamination of the soil and nearby water supplies.

[1] http://www.drugabuse.gov/publications/research-reports/methamphetamine-abuse-addiction/what-methamphetamine

Criminals are becoming bolder and more innocent people are being put in harm's way as meth manufacturers combine these toxic chemicals during the manufacturing process.

For example, last March, Investigators with the Greenville County Sheriff's Office in South Carolina seized a meth lab where a child was present. After processing the site, Sheriff's Deputies learned through their investigation that just minutes before they entered the residence, a three year old girl actually held the meth lab bottle while the reaction was taking place. Fortunately, this ticking time bomb did not ignite or explode while the child had the reaction vessel in her hands. However, after further examination by medical personnel, the little girl tested positive for methamphetamine in her system because she had been present in the meth manufacturing environment.

The expansion of meth labs are unfortunately becoming so frequent in our state that local news outlet WSPA in Spartanburg County maintains a meth lab tracker to inform the public of incidences.[2] Law enforcement data further demonstrates the rapid increase in meth lab discoveries within our state.

[2] http://www2.wspa.com/methlocations/

Reported Clandestine Laboratory Incidents in South Carolina[3]

Year	Reported Incidents
January 1, 2007 to December 31, 2007	26
January 1, 2008 to December 31, 2008	56
January 1, 2009 to December 31, 2009	99
January 1, 2010 to December 31, 2010	125
January 1, 2011 to December 31, 2011	267
January 1, 2012 to July 1, 2012	302

According to the El Paso Intelligence Center ("EPIC"), South Carolina is now one of the top ten meth manufacturing states in the nation.[4] Despite several legislative and regulatory attempts to combat domestic meth production in our state, the above data clearly shows illicit meth manufacturing continues to rise at alarming rates.

Problem

This rapid increase in domestic meth labs has placed law enforcement personnel and our communities at a tremendous health and safety risk and has drastically burdened resources during these dire economic times. Most meth labs in South Carolina are found in a home or car and are usually discovered from a tip provided to law enforcement by a concerned person. There are many instances of meth labs violently exploding or burning due to the volatile nature of various production components. The myriad of toxic chemicals and fumes within a meth production environment often cause immediate respiratory, eye, and skin irritation. Let me be clear, entering a meth lab site is one of the most dangerous acts a law enforcement officer can do.

[3] http://www.justice.gov/dea/concern/map_lab_seizures.html
[4] http://www.lsureveille.com/news/national-methamphetamine-lab-seizures-rose-again-in-2011-1.2705055#.T_90QJEt2So

In addition to this dire health and safety risk, our State is being forced to allocate an unsustainable amount of financial resources to meth lab investigations and hazardous waste removal from these sites. Since 2007, federal and state authorities have spent more than $3 million to remove the gross contaminants from meth lab sites in South Carolina. This figure certainly does not include the cost incurred by local law enforcement, fire, medical, and environmental services that respond to these sites. Furthermore, this amount does not include the cost associated with decontaminating meth lab sites of all meth lab manufacturing contaminants. Recent changes in the Drug Enforcement Administration's policy to no longer pay for the removal of gross contaminants at meth lab sites has led South Carolina to fund the decontamination of these sites with State funds.

Solution

The aforementioned safety risks and resource strains are absolutely unnecessary. There is a way to solve the domestic meth lab epidemic. However, the law enforcement community needs your assistance in combating domestic meth manufacturing.

Over the past decade, several states and Congress have passed legislation in an attempt to combat the meth lab epidemic. Most of this legislation has sought to control access to meth's main ingredient, ephedrine ("EPH") and pseudoephedrine ("PSE"), which are main ingredients in cold medicines. An important piece of federal legislation was the Combat Methamphetamine Epidemic Act of 2005 ("CMEA"). This Act sought to limit a person's ability to purchase more than 3.6 grams of EPH/PSE per day and 9 grams per month. Although over-the-counter products contain varying amounts of EPH/PSE, these limits still allow an individual to purchase as much as one to three boxes of cold medicine per day up to the nine-gram monthly limit. In addition to these limits, the legislation requires retailers to maintain paper records of those persons who

purchase EPH/PSE based products and make these records available to law enforcement for inspection.

The intent of Congress in 2005 was to limit the daily purchases of products containing EPH/PSE, thus restricting the amount of this necessary precursor chemical in the marketplace being diverted for the domestic manufacturing of methamphetamine. Despite the good intentions of CMEA, we can now see that it has not been effective. The approach taken by Congress to solving the meth epidemic to this point is comparable to fixing a gushing, broken water faucet with cotton swabs. The precursor limitation approach simply attempts to mask the problem without targeting the source.

The pharmaceutical industry supports tracking precursor chemicals and brought forward a potential solution known as The National Precursor Log Exchange System ("NPLEx"). NPLEx was implemented in South Carolina on January 1, 2011, and provides law enforcement with an investigative tool to identify persons who purchase unusually high amounts of EPH/PSE products.

The intent of NPLEx was to better electronically track EPH/PSE purchases through a central, interlinking database. Despite the good intentions of NPLEx to better track and limit illicit EPH/PSE purchases, it has not stopped domestic meth manufacturing in South Carolina. NPLEx is not limiting illicit purchases. In fact, in our first year of utilizing NPLEx, South Carolina actually saw an increase in discovered meth labs. According to data maintained by SLED, since February of 2012, only ten percent of the meth lab seizures by law enforcement in South Carolina were the result of the use of NPLEx.

NPLEx has shown that since January 1, 2011, there have been 1,873,148 EPH/PSE transactions in South Carolina. These transactions have been conducted by 695,696 people.

Since there are approximately 4.6 million people in South Carolina, these numbers indicate that no more than fifteen percent of our State's population is buying these EPH/PSE products. Despite common perceptions that a plethora of South Carolinians utilize EPH/PSE based products, data provided by the pharmaceutical industry indicates only fifteen percent of the State's population actually purchase these products.

Any legislation that seeks to merely lower the purchase limit or track purchases does not effectively combat domestic meth production. It is too easy for criminals to subvert the CMEA and NPLEx through the practice of "smurfing." Smurfing is the act of employing a number of individuals for the sole purpose of purchasing the maximum daily and monthly limits of EPH/PSE based products and diverting these products to a person or persons that are engaged in the methamphetamine manufacturing process.

For example, meth manufacturers know they can only purchase the CMEA limit of 3.6 grams of EPH/PSE per day. Although this amount can be processed into a small amount of methamphetamine, it certainly cannot be used by many people for an extensive high. To seek more EPH/PSE for additional methamphetamine production, manufacturers employ individuals to travel to retailers to purchase their legal limits. Manufacturers then receive the EPH/PSE from the multiple people they have employed and produce more methamphetamine from the additional EPH/PSE they have accumulated from the "smurfers". Smurfing is a common practice seen by law enforcement officers throughout South Carolina and is indicative of large scale manufacturing organizations with the intent of distributing their product after manufacturing. The CMEA strategy to track EPH/PSE purchases assumed people would abide by the purchase limitation and use their own form of identification to make the purchase.

However, the unintended but actual consequences of this strategy are that "smurfers" often use fraudulent forms of identification, thus rendering the tracking system ineffective.

Despite CMEA and NPLEx, South Carolina has not seen even the slightest downturn in meth production. Instead, we have experienced the exact opposite. Domestic meth manufacturing is increasing and will likely continue to increase unless Congress enacts targeted legislation to combat our nation's meth epidemic. Despite all of our diligent efforts with current resources and the access to tracking data provided by NPLEx, law enforcement is overwhelmed.

There is good news in this meth epidemic story, and my law enforcement colleagues from the states of Oregon and Mississippi bear witness as to how domestic meth manufacturing can be virtually eliminated. In response to the growing meth crisis, Oregon and Mississippi passed new laws to prevent ephedrine and pseudoephedrine from entering the criminal marketplace. Their laws now require a prescription to purchase an EPH/PSE based product. It essentially returns these products to their proper role in the marketplace as excellent cold medicines, rather than the key ingredients for a dangerous, toxic, and highly-addictive narcotic. The results of Oregon's and Mississippi's targeted legislation have proven to be the most effective approach to combating domestic meth production within those states.

If we are serious about combating domestic meth production, Congress must pass legislation returning ephedrine and pseudoephedrine to prescription only. We have seen the absolute success of this approach in Oregon and Mississippi as meth manufacturing has plummeted in those states. The rescheduling of ephedrine and pseudoephedrine has had a direct causal effect in the decrease of local meth production.

While it is certainly within the purview of state governments to consider scheduling these products, I sincerely believe federal action to schedule is the best practice. Meth manufacturing

is highly mobile, and it is likely that as states begin to individually schedule EPH/PSE, meth manufacturing criminals will simply move and concentrate their operations in states with easy access to these products. Criminals will then transport their toxic product throughout the country via our nation's highways. A national approach is needed to solve the meth lab epidemic because of the interstate impacts of domestic meth production and transportation.

Conclusion

South Carolina has many great achievements to celebrate. Our newspaper headlines are filled with economic development success stories and great accomplishments of our talented and hardworking people. However, these headlines are often stained by the tragic reality of our meth lab epidemic.

In May of this year, a horrific fire destroyed sixteen apartment units in the Pine Harbour apartment complex in Goose Creek, South Carolina, killing three people. The victims of this tragedy were:

- 4 year old Samuel Garbe
- 19 year old Morgan Abernathy
- 69 year old retired Air Force Captain and Vietnam Veteran Joseph Raeth

These people did nothing wrong. They were victims of circumstance. Their circumstance was that they were in their apartment in close proximity to a meth lab. Although the manufacturing of meth cannot be exclusively proven to be the cause of the fire, it appears based upon information present at the scene that it most certainly may have contributed to the spread of the fire. During this manufacturing process, something went wrong and a fire ensued causing the destruction of sixteen apartment units in the complex and the death of three innocent victims. This is the reality.

Let me be clear. The majority of methamphetamine consumed in America is produced in super labs, most of which are outside this country. My comments today are not intended to convince you that the scheduling of EPH/PSE will absolutely solve the methamphetamine problem in America. However, my position is that enacting targeted legislation to restrict the sale of EPH/PSE products will essentially eliminate the domestic meth lab epidemic in the United States.

President Ronald Reagan once said:

> ***"To sit back hoping that someday, some way, someone will make things right is to go on feeding the crocodile, hoping he will eat you last – but eat you he will".***

Committee Members – the crocodile is alive and well and is preying on our criminal justice system, our environment, our health care system, our social welfare system, and our economy. This Committee has an opportunity to put the crocodile back in its cage and stop domestic meth labs in this Country by rescheduling ephedrine and pseudoephedrine.

Thank you for your time and I will be happy to answer any questions the Committee may have for me.

Mr. GOWDY. Thank you, Agent Dorsey.
Mr. Bovett.

STATEMENT OF ROB BOVETT

Mr. BOVETT. Chairman Gowdy, Ranking Member Davis, and members of the committee, my name is Rob Bovett. I am the district attorney for Lincoln County, Oregon, but I guess more importantly today, I am here as legal counsel for the Oregon Narcotics Enforcement Association. As such, I helped craft much of Oregon's drug policy and laws that addresses not just enforcement, but treatment and prevention.

I am here today to talk specifically about pseudoephedrine control and effective pseudo control. I am not here to talk about reducing the meth epidemic. I am here to talk about reducing the domestic manufacture of meth. The truth is most meth comes from Mexico, and it has for a long, long time. We are talking about the impacts, the devastating impacts of meth labs.

In 1976, we let the genie out of the bottle. We allowed pseudoephedrine to be sold over-the-counter. It was a mistake. It was a huge mistake. Ever since then, we have been putting Band-Aids on the situation for the last 35 years, both in State legislatures and in Congress. It hasn't worked. The Band-Aids have been temporary patches on what is effectively a gaping wound. And here we are again. Here we are again with the smurfing epidemic that is pervasive across our Nation. It does manifest itself differently in different parts of the Nation.

In the Midwest and the South, all of the smurfing of pseudoephedrine fuels thousands, tens of thousands of these one pot user labs. In the West Coast, it is different. All of the smurfing fuels super labs in central California. California produces more meth in domestic meth labs than the next four States combined. So we have a slightly different problem in the West Coast than in the Midwest and the East and the South. But the problem all stems from the same core problem, smurfing, smurfing, smurfing of pseudoephedrine.

In 2006—actually, in 2005 we passed legislation in Oregon to return pseudoephedrine to a prescription drug and end the smurfing problem. It went into effect in 2006. And we eliminated smurfing. It can't be done in Oregon. It can't be done in Mississippi. And I should say there was a parade of horribles ramped up, and it is still ramped up today about all the things that would happen. There would be public outcry, demonstrations. There would be home invasions. There would be robberies of pharmacies. There would be doctors' offices swamped with people.

The truth is it has been over 6 years in Oregon, and none of that has happened. None of it. The truth is that we effectively eliminated the problem of smurfing in Oregon. We no longer contribute to the domestic meth lab problem. And there is no one clamoring to undo what we did over 6 years ago. It is a real solution to end the problem of smurfing, to correct a mistake that should never have been made 35 years ago.

But only Congress can actually fix this nationwide because, yes, Oregon has a handful of meth labs remaining each year, but it is all traced back to pseudoephedrine smurfed, as the director men-

tioned, in Washington or Idaho or California; in one case, Nevada. So we truly need a nationwide solution to this nationwide-created problem from 1976.

The truth is also that most consumers have long ago switched to alternative decongestants. When you enacted the Combat Meth Epidemic Act in 2006, in the spring of 2006, and it went into effect September of 2006, virtually by that time, most consumers had long switched to stuff that was easy to access. Hundreds of products line the shelves. We are not talking about those products. We are talking about 15 remaining pseudoephedrine products that are all behind the counter. And so we see massive smurfing going on in places other than Oregon and Mississippi.

I will tell you, and I have provided you references in my written testimony, that our medical community overwhelmingly not only supports but strongly supports what we did in 2005 that went into effect in 2006, including the Oregon Medical Association, our pharmacists, and our college of emergency physicians. Because it works. It not only works and it is effective, it didn't flood their offices with demands for these products that most consumers just simply don't seek. It is a real solution. I appreciate the time. We need to put this genie back in the bottle, and only Congress can do that. I look forward to your questions, and thank you very much for the time.

[The prepared statement of Mr. Bovett follows:]

Statement of Rob Bovett
District Attorney, Lincoln County, Oregon
Legal Counsel, Oregon Narcotics Enforcement Association

before the

Subcommittee on Health Care, District of Columbia, Census and the National Archives

of the

Committee on Oversight and Government Reform

of the

United States House of Representatives

RETURNING PSEUDOEPHEDRINE TO A PRESCRIPTION DRUG

to end the

RESURGENCE OF DOMESTIC METH LABS

Tuesday, July 24, 2012
Room 2247
Rayburn House Office Building
Washington, DC

Dear Chair Gowdy, Vice-Chair Gosar, Ranking Member Davis, and Subcommittee Members Burton, Clay, Desjarlais, McHenry, Mica, Murphy, Norton, and Walsh,

Thank you for providing me the opportunity to discuss the important public health and safety issue of domestic meth labs, and how they can be prevented.

Pseudoephedrine (PSE) is the key ingredient necessary to make the most powerful variety of methamphetamine that addicts seek.[1] PSE is the precursor used in virtually all current meth labs in the United States.

Ten critical points:

1. In 1976, the Food and Drug Administration let a genie out of the bottle by permitting PSE to be sold over-the-counter. Ever since, Congress and states have put **band-aids** on the problem of retail PSE diverted to make meth, providing temporary relief, at best.[2]

2. The Oregon legislature **returned PSE to a prescription drug**, effective July 1, 2006.[3]

3. In 2007, **Mexico** followed Oregon's lead, and then went one step further by **banning PSE entirely**. The effect has been weaker meth coming out of Mexico – and more pressure to cook more potent meth in the United States using diverted retail PSE.[4]

4. The diversion of retail PSE to make meth typically comes in three forms of what is commonly known as "**smurfing**:" (a) Exceedence smurfing; (b) group smurfing; and (c) false ID smurfing.

5. **Electronic monitoring** of PSE sales has the ability to stop or identify exceedence smurfing, where an individual goes from pharmacy to pharmacy using the same ID. However, electronic tracking does not have the ability to stop, and is completely **evaded by**:

   (a) **Group smurfing**, where no single individual exceeds the retail sales limit; and

   (b) **False ID smurfing**, where an individual uses multiple false ID's to smurf more than the legal limit.

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[1] It is also possible, using the same simple "reduction" process, to make the powerful variety of methamphetamine from ephedrine, and similarly to make amphetamine from phenylpropanolamine. Those two drugs are similar to PSE in both chemical structure and effect as decongestants. However, both are no longer on the market, due to safety issues. *See* www.oregondec.org/IN/Tab15.pdf at page 1198, second paragraph, and accompanying footnotes.

[2] For a detailed examination of this tortured history, *see Meth Epidemic Solutions*, 82 North Dakota Law Review 1195 (2006), www.oregondec.org/IN/Tab15.pdf. *See also* "The Meth Epidemic," FRONTLINE, PBS, www.pbs.org/wgbh/pages/frontline/meth/.

[3] The Oregon legislation returning PSE to a prescription drug in Oregon was contained in Enrolled 2005 Oregon House Bill 2485: www.leg.state.or.us/05reg/measpdf/hb2400.dir/hb2485.en.pdf. The PSE provisions are in Sections 11 through 13a on pages 5 through 8 of that enacted legislation.

[4] Meth production in Mexico by Drug Trafficking Organizations (DTOs) has since switched to more technically complicated methods of manufacture that do not require PSE, and produce meth that is half as potent as meth produced with PSE. The DTOs also use methods to enhance the potency of the weaker meth, but do not achieve the potency of meth produced with PSE.

6. **Electronic tracking** helps to **facilitate group smurfing**, and a PSE black market, by ensuring that no individual smurfer exceeds the retail sales limit. Smurfing of PSE now fuels thousands of meth labs each year across the Midwest and South, and fuels the "super labs" in Central California run by large drug trafficking organizations.[5]

7. **Smurfing also fuels addiction** within a community, by enabling addicts to buy a box of PSE for $5 and exchange the PSE directly for drugs, or sell the PSE at a massive markup on the black market, and then buy drugs with the profits.

8. In contrast, **returning PSE to a prescription drug eliminates all forms of smurfing**. Oregon has eliminated smurfing and is no longer a part of the problem. Further, with over six years of actual experience, there has not been a single reported meth lab incident where diverted prescription PSE was used to make meth in Oregon. PSE doctor shopping has not occurred, because PSE is not susceptible to doctor shopping in the same way as pain medicine. The few remaining Oregon meth lab incidents are nearly all located in counties along the Oregon border, and fueled by retail PSE from out of state.

9. **Electronic tracking therefore further delays an effective solution to the diversion of retail PSE** – all at the expense of lives, families, public safety and, most tragically, drug endangered children.

10. Oregon simply put the genie back in the bottle by returning PSE to a prescription drug – a pure **prevention** solution to the problem.[6] More recently, Mississippi replicated this proven solution.[7]

The pharmaceutical industry, and their surrogates, would have you believe a parade of horribles will occur if we return PSE to a prescription drug. Don't believe it. It is a ***false*** parade of horribles, and we have years of experience and evidence to prove it.

There were few complaints, and no public outcry, after PSE was returned to a prescription drug in Oregon on July 1, 2006.

The industry often argues that returning PSE to a prescription drug will drive up Medicaid costs, flood doctor offices, emergency rooms, and pharmacies with people seeking PSE to treat colds and allergies, and have a disparate impact on the poor. None of that occurred in Oregon:

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[5] For an introductory primer on "super labs" and "super smurfing" in the West, *see* the written testimony of Kent Shaw from the California Bureau of Narcotics Enforcement (BNE) before the Nevada Legislature last year: www.oregondec.org/NV/Testimony-KS.pdf.

[6] Since Oregon's prescription-only law took effect, meth lab incidents have dropped by 96 percent and meth-related arrests by 32 percent. www.politifact.com/oregon/statements/2011/apr/02/rob-bovett/oregon-district-attorney-says-meth-lab-seizures-an/. Oregon also experienced a 33 percent reduction in meth treatment admissions, and a 35 percent reduction in meth-related emergency room visits. www.oregondec.org/OregonFactSheet.pdf.

[7] *See* Statement of Marshall Fisher, Director of the Mississippi Bureau of Narcotics, submitted today.

- With respect to impact on Medicaid, the Oregon Department of Human Services, which administers the Medicaid program in Oregon, has indicated the total economic impact on Medicaid from returning PSE to a prescription drug is about $7,780 per year.[8]

- With respect to impact on the poor, a couple years after the Oregon law went into effect, I asked the staff of the Oregon Criminal Justice Commission to make inquiries (they served as staff to the Oregon Meth Task Force, which I Chaired at the time). They were able to make contact with the directors of key service providers, and confirmed there was no disparate impact. By way of example, the Director of Northwest Human Services, which runs free clinics and homeless shelters in Salem, Oregon, checked with his clinic and shelter managers. The response: "We haven't heard a peep from either the patients or the providers since the change to pseudoephedrine. There are so many good alternatives that it isn't an issue."

- With respect to flooding hospitals, doctor offices, and pharmacies, a letter from the Oregon Chapter of the American College of Emergency Physicians (OCEP) indicates there was virtually no impact whatsoever; OCEP strongly supports the Oregon legislation, as does the Oregon Medical Association (OMA).[9] The Oregon State Pharmacy Association (OSPA) also strongly supports the Oregon legislation and, in the spring of 2008, conducted a survey of their membership, confirming that Oregon pharmacists strongly prefer PSE as a prescription drug.[10]

There are now only 15 products, and their generic equivalents, that even contain PSE.[11] All of these products are already behind-the-counter. Most consumers simply purchase non-PSE over-the-counter products that line store shelves.[12]

The industry's surrogates also trot out flawed estimates of retail PSE diversion rates,[13] and flawed industry-funded studies that attempt to cast doubt on the efficacy of returning PSE to a prescription drug, but ignore key facts and data.[14]

In Kentucky, the home of the industry-touted PSE electronic tracking system that has failed to reduce meth lab incidents, the industry has spent a record-breaking amount of money to stop Kentucky law enforcement from getting legislation passed to return PSE to a prescription drug.[15]

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[8] The letter can be viewed at: www.oregondec.org/CASB484/DHS.pdf.

[9] The letter from OCEP can be viewed at: www.oregondec.org/CASB484/ACEP.pdf. The letter from the OMA can be viewed at: www.oregondec.org/OMA.pdf.

[10] The letter from OSPA can be viewed at: www.oregondec.org/CSPSC/007-OSPA.pdf.

[11] *See* www.oregondec.org/15.pdf.

[12] *See also* Statement Supporting Prescription-Only Pseudoephedrine Legislation, Allergy and Asthma Network, Nancy Sander, President, and Stuart W. Stoloff, MD, Board Chairman, www.oregondec.org/AANMA-PositionPaper.pdf.

[13] *See, e.g.*, www.oregondec.org/PSE-DiversionEstimate-KentShaw.pdf.

[14] The most recent example is an industry-funded and flawed study by the Cascade Policy Institute. *See* www.oregondec.org/ReplyToCascade.pdf.

[15] *See* "Meth, money and lobbying: Guess who's biggest spender again," *Lexington Herald-Leader* (June 5, 2012), www.kentucky.com/2012/06/05/2212626/meth-money-and-lobbying-guess.html. *See also* kynarc.org.

As others have testified, there has been a significant recent resurgence of domestic meth lab incidents. Not coincidentally, PSE imports into the United States went up 43% from 2008 to 2010. Retail sales of PSE in the United States directly fuel the resurgence of domestic meth manufacturing.

Returning PSE to a prescription drug will end smurfing and drive down domestic meth lab incidents. Meth makers will not have the ability to simply switch to other precursor drugs. The other methods of making meth without PSE require chemicals that are difficult to obtain, use processes that require more complex organic chemistry, and produce less potent meth. These are beyond the ability of average "user" meth cooks.

It is also important to make clear that each meth lab, no matter how great or small, poses an unacceptable threat to public health and safety. Even the smallest "one pot" meth labs poison their environment, often catch fire or blow up, and leave human tragedy and significant property owner and public expense in their wake, including the costs of cleanup, remediation, public safety, and medical care at burn units, to name just a few.

Especially with regard to "one pot" and other small "user" meth labs, most tragic are the drug endangered children who are forced to live in these toxic environments.[16] This is unconscionable, and must end.

It is long past time that Congress enacted an effective remedy for this unacceptable situation. We don't need any more band-aids on this gaping wound. We need a real solution.

Thank you again for the opportunity to discuss this important national public health and safety issue. Please don't hesitate to contact me if I can be of any further assistance. More information on this topic can be found at www.oregondec.org/pse.htm.

Sincerely,

Rob Bovett
District Attorney, Lincoln County, Oregon
Legal Counsel, Oregon Narcotics Enforcement Association

enc: New York Times Op Ed (2 pages)
Drug Policy Bio (1 page)

[16] The tragedy and hazards of children in meth lab environments is well documented, both in the media and in studies. *See, e.g.,* the series of studies conducted by the National Jewish Medical and Research Center, copies of which are posted at: www.oregondec.org/documents.htm.

The New York Times

OP ED

How to Kill the Meth Monster

November 16, 2010
By ROB BOVETT

Newport, Ore.

THE latest bad news from the world of methamphetamine is that makers of the drug have perfected a one-pot recipe that enables them to manufacture their highly addictive product while on the move, often in their car. The materials they need — a two-liter soda bottle, a few cold pills and some household chemicals — are easily obtained and easily discarded, often in a trash bag dumped along the highway.

There is, however, a simple way to end this mobile industry — and, indeed, most methamphetamine production. We've tried it in Oregon, and have seen how well it works. Just keep a key ingredient, pseudoephedrine, out of the hands of meth producers.

Pseudoephedrine is a nasal decongestant found in some cold and allergy medicines. In 1976, the Food and Drug Administration allowed it to be sold over the counter, inadvertently letting the genie out of the bottle. Afterward, the meth epidemic spread across the nation, leaving destroyed lives and families in its wake.

Sales of products containing pseudoephedrine in the United States now amount to nearly $600 million a year. Yet, according to the pharmaceutical industry, only 15 million Americans use the drug to treat their stuffed-up noses, and these people typically buy no more than a package or two ($10 to $20 worth) a year.

Over the years, Congress and state legislatures have passed laws meant to prevent the diversion of pseudoephedrine to meth production. But such efforts have amounted to only temporary Band-Aids.

In 2006, Congress required pseudoephedrine products to be moved behind the counter, set daily and monthly limits on the amount that can be sold to any one customer and required retailers to keep a

log of sales. But meth users quickly learned to evade these controls by making purchases in several different stores — a practice known as "smurfing."

In an effort to avoid having more stringent controls placed on the drug, the pharmaceutical industry is lobbying Congress to require electronic tracking of pseudoephedrine sales, as some states already do. This makes it harder for an individual smurfer to collect large quantities of the drug. But meth users get around the tracking system by banding together in cooperatives, with each member buying pseudoephedrine products in amounts small enough to evade detection. These group smurfers then contribute their portion to the pot in exchange for cash or a share of the cooked-up meth. Or, in the West, they feed the "super labs" run by drug trafficking organizations in Central California.

In Kentucky, an electronic tracking law that went into effect in 2008 has had no effect on the number of meth labs there, and only 10 percent of them are found by electronic tracking. The number of police incidents involving meth labs has actually increased by more than 40 percent.

The only effective solution is to put the genie back in the bottle by returning pseudoephedrine to prescription-drug status. That's what Oregon did more than four years ago, enabling the state to eliminate smurfing and nearly eradicate meth labs. This is part of the reason that Oregon recently experienced the steepest decline in crime rates in the 50 states.

Earlier this year, Mississippi also passed a law requiring a prescription to get pseudoephedrine. Since July, the number of meth labs in that state has fallen by 65 percent.

In 2009, Mexico, which had been the source of most of the methamphetamine on the streets of the United States, went further, banning pseudoephedrine entirely. The potency of meth from Mexico has since plummeted. This is great news. But now the ball is back in our court.

These pseudoephedrine prescription requirements apply to only 15 pharmaceutical products and their generic equivalents — medicines like Sudafed 12 Hour, Aleve D and Advil Cold and Sinus. Most cold and allergy medicines on store shelves are not affected, because they contain no pseudoephedrine.

Senator Ron Wyden of Oregon has proposed legislation to require prescriptions for products with pseudoephedrine nationwide, and Congress should enact it without delay. American families, too many already devastated by the meth epidemic, deserve no less.

Rob Bovett, the district attorney for Lincoln County, Ore., was the primary author of Oregon's anti-methamphetamine laws.

Mr. GOWDY. Thank you, Mr. Bovett.
Mr. Fisher.

STATEMENT OF MARSHALL FISHER

Mr. FISHER. Mr. Chairman, Ranking Member Davis, committee members, on behalf of the State of Mississippi, we appreciate you having—I appreciate being here today.

I am a 35-year veteran of law enforcement, been the director of Mississippi Bureau of Narcotics for the past 7 years. Prior to that, I was a Special Agent with the Drug Enforcement Administration. My first undercover narcotics purchase as a street agent was methamphetamines. That was some time ago, when my hair wasn't gray.

In 2005, Mississippi passed several new laws designed to curb methamphetamine production. One of them was limiting the amount to 3.5 grams on a daily basis and up to 9 grams in a 30-day period. The other was to require a log to be signed by individuals purchasing the pseudoephedrine, wherein they would have to provide some form of identification. We saw an initial decline in labs about 18 months into those laws being passed. Then they began to steadily climb. In 2009, we recorded 713 meth labs in the State; 129 children being taken away as what we call drug-endangered children being taken out of meth labs, many of whom had been physically and sexually abused. We had over 3,000 arrests from my agency alone that year, and one third of them were for narcotics for the first time—for methamphetamine. For the first time in the history of the State of Mississippi, they exceeded the combined total of crack and powder cocaine, those arrests.

So we began to figure out what we were going to do as a solution. We looked at electronic tracking. You have already heard from some of the other witnesses here today about Kentucky. It was considered a gold standard State. I did a tour in Kentucky with the Drug Enforcement Administration; I had colleagues that were still there, still on the job, who told me it simply wasn't working. Their meth labs were increasing. I talked to a judge in the State of Mississippi who routinely removed children of drug addicted parents from the custody of those parents. And he told me in the entire time he has been on the bench, he has never removed one child from a meth-addicted parent where the parents come back to court to even bother to petition the court to get the child back. He also told me numerous anecdotal stories of children, preschoolers who had STDs passed to them, sometimes by their own parents, meth-addicted parents.

We came to the only viable solution that we thought would do this after some intensive study, and that was to make pseudoephedrine prescription only. We enacted the law in 2010. We have had 2 years to study it, to see the results of what has happened here—has happened and would happen in Mississippi. We had the same parade of horribles, including the cost of Medicaid going up. And I actually have a document with me from the director of Medicaid in Mississippi for the record if you would like it later, showing that there has been absolutely no effect on over-the-counters. There was a requirement for prescription for over-the-counters already anyway from the Medicaid department.

We had 546 total meth incidents in the first two quarters of 2010. In the same two quarters of this year, we have had 162. More importantly, in the first two quarters of 2010, from January through June, we had 252 actual methamphetamine labs. In the first two quarters of this year, we have had 17. Seventeen. That is a 93 percent reduction. And the only thing we have done different is schedule pseudoephedrine. The numbers speak for themselves.

Our supporters of the prescription legislation wanted to adequately support law enforcement, protect our children, and preserve public safety. We like to say in Mississippi, there is no middle ground on meth labs; you are either for meth labs or you are against them. This is a self-created, self-inflicted epidemic that we can do something about here in the United States of America.

We cannot control what the people in the Republic of Mexico do, and Afghanistan, and some of the other places, Colombia and Peru. We can control this. And it frees people up, investigators up to work on organizations who are actually bringing in methamphetamine, such as the Mexican cartels.

Prescription-only legislation is not just the right choice; it is the only legitimate choice for this country. We would have money freed up for treatment of addicts. It would be astounding numbers.

Most of the people with the one pot methods that we are seeing are addicts, 99 percent of them. One- to three-yield grams, one pot method. Most of these people are addicts. Putting an addict in prison is like painting your house when it is on fire. It is not a solution. Thank you for your time.

[The prepared statement of Mr. Fisher follows:]

STATEMENT OF MARSHALL FISHER

EXECUTIVE DIRECTOR

MISSISSIPPI BUREAU OF NARCOTICS

BEFORE THE

SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"THE STATUS OF METHAMPHETAMINE: MISSISSIPPI'S EXPERIENCE MAKING PSEUDOEPHEDRINE PRESCRIPTION ONLY"

JULY 24, 2012

Introduction

In 2005, Mississippi passed several new laws designed to curb the increase in production and use of crystal methamphetamine in Mississippi. House Bill 605 restricted access to pseudoephedrine by limiting the amount an individual could purchase or possess; and Senate Bill 2235 made precursor drug or chemical possession evidence of intent to manufacture methamphetamine. Unfortunately, these laws were not effective. After an initial decline, individuals easily adapted by purchasing the legal allowable amount of products at one retail outlet, followed by successive purchases at other stores using multiple buyers and multiple forms of identification. This practice is known in street vernacular as "smurfing."

By 2009 the Mississippi Bureau of Narcotics (MBN) recorded the following:

- Over 713 methamphetamine labs; the highest ever recorded in the state.
- 129 drug endangered children in Mississippi, many of whom were taken into state child protection services; some of whom were physically and sexually abused.
- Methamphetamine-related arrests exceeded the combined total of both powder and crack cocaine arrests for the first time in Mississippi drug law enforcement history. Of approximately 3,000 drug arrests for 2009, nearly one-third were methamphetamine related.

These statistics indicate that the 2005 legislation did not work. The MBN and other interested groups questioned: "How will the State of Mississippi battle the growing methamphetamine problem with declining revenues?"

In trying to answer that question, MBN considered the use of electronic tracking logs to monitor purchases, but determined that all electronic logs have two major flaws:

- First, electronic logs require the expenditure of concentrated, costly law enforcement resources in order to establish the logs in real time, to monitor and investigate leads, and to take down methamphetamine production organizations. The cost of implementing an electronic log system would not significantly offset the costs of methamphetamine abuse, such as the clean-up of lab sites, societal costs of caring for endangered children, mental health services for methamphetamine users, and the cost of prosecution and incarceration.
- Second, individuals know how to adapt to electronic logs—electronic tracking does *not* block false identifications and does not stop the multiple numbers of smurfers--thus rendering electronic logs ineffective.

The methamphetamine epidemic is truly unnecessary and self-created. Electronic tracking of pseudoephedrine purchases is and will continue to be a failure. States that have adopted electronic logs and behind-the-counter approaches have noted that methamphetamine lab activity has actually dramatically increased. Exemplary evidence of the myth of the success

of electronic tracking can be seen in Kentucky. Despite the fact that electronic tracking has been underway there for several years, the number of labs in Kentucky is steadily increasing. I heard one obviously uninformed officer, a supporter of electronic tracking, claim that he cares about his officers, and wants to ensure they have the best tools to do their job. Such tools as electronic logs will not be necessary, however, if pseudoephedrine is scheduled.

The simple truth is that the only way to stop methamphetamine labs is to more effectively control access to the main precursor chemicals: pseudoephedrine and ephedrine. An increase in law enforcement resources dedicated to that purpose, however, was considered unrealistic in lean budget years. We in law enforcement want to eliminate methamphetamine labs. Our budgets and manpower, however, simply will not allow us to continue to track pseudoephedrine purchases or follow addicts around, nor do we want to. Moreover, the federal lab clean-up program is dismantling and is not likely to return, leaving to the states the additional responsibility of funding lab clean-up.

OVERVIEW

After analyzing the various issues related to decades of methamphetamine production in Mississippi and the United States, the Mississippi Bureau of Narcotics, with full support of the Governor of the State of Mississippi, determined that the only answer was to schedule pseudoephedrine and ephedrine.

In the 2010 Mississippi legislative session, both bodies of the Mississippi legislature passed House Bill 512 by an overwhelming majority. The bill created a prescription requirement for pseudoephedrine, replacing the requirements for over-the-counter purchases, which consisted of providing identification and signing logs - electronic or manual. Although the matter was somewhat controversial among certain members of our legislature, we educated our members in the halls of the capitol and other venues, and were able to answer their questions and correct the misinformation that the pharmaceutical industry had provided in furthering their own agenda, which was to increase their profits. A host of lobbyists descended on Mississippi to convince both the public and the legislature that potential consequences--such as skyrocketing Medicaid costs, and elderly citizens and children of soccer moms being denied cold and allergy medicine--were valid reasons to oppose the prescription requirement. Pharmaceutical industry lobbyists continued to provide misleading and false information to lawmakers and the public right up until the final vote. Contrary to the misleading representations by the pharmaceutical industry, doctors and other prescribers in the medical community say none of this has occurred. In fact, Medicaid officials recently indicated that the passage of House Bill 512 has had no effect on Medicaid costs because the program already required a prescription for reimbursement of pseudoephedrine product purchases.

Two years after the passage of this landmark legislation, the number of methamphetamine incidents in Mississippi is down more than 70 percent. The number of actual methamphetamine labs in Mississippi is down more than 90 percent. Hinds County, Mississippi, Judge William Skinner, who routinely removes children from the custody of drug-addicted parents, has stated that he has never had one methamphetamine-addicted parent petition the Court to reclaim custody of their children: not one. So perhaps the most important statistic is that the number of drug endangered children removed from methamphetamine labs in Mississippi is down nearly 80 percent.

Since this law went into effect in July 2010, our state narcotic agents are no longer chasing, seizing, and prosecuting the tremendous number of labs, which created a severe drain on manpower and resources. They are now able to focus their efforts and resources on wide-ranging narcotics investigations. The small "one-pot" methamphetamine labs now found in Mississippi are typically generated by addicts supporting their habit. Sending addicts to prison is like painting your house when it is on fire; it does not solve the problem. While we still have some labs in Mississippi, we have seen a drastic reduction in their numbers and size, and the only thing Mississippi did differently was to schedule pseudoephedrine.

There have been recent representations claiming that the number of labs in Mississippi is virtually the same as in Alabama; however, that statement is untrue and misleading. Alabama authorities have reported that they are no longer responding to methamphetamine labs because the federal government is no longer paying to clean up the labs. In addition, although some of our bordering states are refusing to sell precursor drugs and chemicals to Mississippi residents, the precursors we are seeing are *all* coming from our neighboring states. We believe if all four of our bordering states were to schedule pseudoephedrine, methamphetamine labs would be eliminated almost entirely in Mississippi. As a law enforcement officer with more than three decades of experience, twenty-nine years of which has been in narcotics, the scheduling of pseudoephedrine in Mississippi may be our most effective piece of law enforcement legislation in the last 30 years. Our officers do not deserve to be exposed to the dangerous chemicals found at these hazardous waste sites that once housed methamphetamine labs. Our citizens and our children do not deserve it either.

I can only hope that our nation is able to get a grasp on this problem and that we pursue the only viable solution, which is to schedule pseudoephedrine on a national level. We cannot and will not arrest ourselves out of this self-created public health issue.

CONCLUSION

The state of Mississippi enacted "prescription only" legislation that went into effect in July 2010. In that two year period Mississippi has seen a remarkable 70% reduction in methamphetamine incidents (546 total incidents in the first two quarters of 2010, compared to 162 incidents in the first two quarters of 2012) and a 93% reduction in actual methamphetamine labs (252 actual methamphetamine labs in the first two quarters of 2010, compared to 17 in the first two quarters of 2012). These numbers speak for themselves. The supporters of prescription-only legislation wanted to do the right thing: adequately support law enforcement, protect children, and preserve public safety. There is no middle ground when it comes to methamphetamine labs; you are either for methamphetamine labs or against them. Electronic tracking is and continues to be a Trojan horse. Prescription only legislation is not just the right choice to achieve these goals on a national level, it is the only legitimate choice.

Mr. GOWDY. Thank you, Mr. Fisher.

The chair would now recognize the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

And thank you all for your testimony, for being here today.

I had a conversation this morning with Tommy Farmer, our great director of Tennessee's meth task force. And he mentioned several of you by name, so I assume you are friends. And we are very fortunate to have him.

Let me start, Mr. Bovett, what kind of kickback have you gotten from the patient population in your State since this law has been enacted?

Mr. BOVETT. Congressman, the short answer and one-word answer is none.

Mr. DESJARLAIS. Okay. So who is in the greatest opposition to Sudafed becoming a controlled substance?

Mr. BOVETT. Congressman, the pharmaceutical industry, and primarily, not directly the pharmaceutical industry, but primarily through their surrogates, various foundations and associations that virtually represent them.

Mr. DESJARLAIS. Mr. Fisher, you concur with that?

Mr. FISHER. Yes, sir.

Mr. DESJARLAIS. Okay. You know, clearly the NPLEx system that we have in Tennessee, I think this panel is saying that it just simply is not effective; it is not working. Back when it was not in place, an individual could go out and buy 100 boxes. Now with smurfing, a 100 individuals go out and buy one box, and there just simply has not been any significant decrease in the number of labs. Is that correct?

Mr. GRELLNER. Yes.

Mr. DESJARLAIS. Okay. Mr. Fisher, or actually Mr. Bovett, I was just looking at some of the numbers. The surrounding States around Oregon, some people say it is just going to increase. It looks like to me the numbers in Washington, Idaho, California have dropped since your law has been passed. Is that just statistical noise or is there a reason for that?

Mr. BOVETT. Congressman, there is a reason for that. We saw a definite drop in meth labs across the Nation, including the Northwest and the West Coast following the Combat Meth Epidemic Act. But the resurgence in the West Coast is different than it is in your part of the Nation. The resurgence in the West Coast is a resurgence toward super labs in California. So there is massive amounts of smurfing going on in cities like Las Vegas and Reno and Phoenix and Seattle every day. But primarily, that fuels the super labs in California, as I mentioned. And so Nevada, for example, held a hearing on this very issue last year and is developing momentum to do this. They have just a handful of meth labs each year. And why would they do that? Because smurfing, as mentioned by the other speakers, smurfing has become an enormous problem in those States with the black market, with even heroin addicts being able to convert $5 to $50 or $100. So it has manifested itself slightly different in the last few years.

I would also caution you about some of the numbers that the industry banters around. They tend to use a Federal database that

is not exactly accurate. For example, Washington State doesn't accurately and fully report their meth lab incidents to the Federal Government. So there are issues relating to that as well.

Mr. DESJARLAIS. Let me play devil's advocate just for a second. I would like to see what your opinions are. Would you all agree that prescription narcotic abuse is on the rise and becoming a huge problem? Okay. So here we have a situation where you have controlled substances, and it is increasing. I am sure if those drugs were over-the-counter, the problem would be astronomically higher. What would you say to critics that say those systems aren't working? If we make Sudafed a controlled substance, why do we think that will work when we already have tools in place?

And—Mr. Grellner?

Mr. GRELLNER. The main reason we have such a prescription drug abuse problem here in the United States is because of opiate pain relievers. And pain is subjective. A doctor such as yourself has to reply on his patient to tell him the amount of pain he is in and the quality of that pain.

This is an objective problem. If you have inflammation in your sinus and ear canals, that can be objectively looked at by the doctor, and the proper medication can be administered by the doctor. They are two different subjects. Prescription drug abuse is a horrible problem, but it is opioid pain relievers at over 5 million abuses a year that is the problem with prescription drug abuse, not pseudoephedrine.

Mr. BOVETT. If I could just briefly add——

Mr. DESJARLAIS. Mr. Bovett.

Mr. BOVETT. —from Oregon's actual over 6 years of experience, we do have, as I mentioned, a handful of meth labs incidents each year. We trace the pseudoephedrine to its source. And in over 6 years of actual experience, we have not had a single meth lab incident where the pseudoephedrine was prescribed pseudoephedrine. For all the reasons that Mr. Grellner has outlined, plus a few more, we just don't see that as a problem, and it hasn't occurred.

Mr. DESJARLAIS. Mr. Grellner, you mentioned burn units.

I just wanted to mention our largest burn unit in Tennessee, Vanderbilt University, right now fully one third of the burn patients there are meth-related burns. And I think our cost is about $10,000 a day.

Mr. GRELLNER. Vanderbilt University burn unit in 2009 spent $9 million of their own money on uninsured meth lab burn victims.

Mr. DESJARLAIS. Unfortunately, that light is red over there. I would love to visit with you more. But thank you.

I yield back.

Mr. GOWDY. I thank the gentleman from Tennessee.

The chair would now recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Let me thank the gentlemen for your testimony. As a matter of fact, I was sitting here thinking that I have heard lots of testimony during the many years that I have been a member of legislative bodies, and yours is perhaps the most compelling that I have heard in terms of a very clear direction for what can become a real impact on—not totally eradicating but certainly putting a serious damper

on a problem. If the information that we have gathered from the Oregon and Mississippi experiences, then it is difficult for me to think of any reason that we couldn't duplicate those experiences throughout the country.

Let me ask, Mr. Brooks, as the national leader, have you heard much reason why we couldn't duplicate across the country the experiences of Mississippi and Oregon?

Mr. BROOKS. Well, I can tell you the primary reason has been the strong push by industry to oppose it. We tried to pass a very similar law in California, SB 486, where we received deep opposition, a very strong lobbying effort by industry to prevent that. They were successful. They derailed our bill. Other States and other local government entities, counties and cities that have tried to schedule pseudoephedrine have had the same experience.

So we really think that the answer here is a national law. We think that the evidence, as you say, sir, is very clear. This works. It is not a hypothesis. It is a proven fact. But we have got to overcome the push, the push by industry. This is a multibillion dollar industry. The over-the-counter pseudoephedrine industry is a multi—there is a lot at stake. And I think we have to collectively as a Nation have the courage to step up and do what is right for our kids and our communities.

Mr. DAVIS. Well, even, I was trying to rationalize why industry—of course, you could see some concern. But then if the products are so good, physicians are going to be prescribing them anyway to a real degree, I would assume.

Dr. DesJarlais, would that not be the——

Mr. DESJARLAIS. If the gentleman would yield, as far as Sudafed being so good, phenylephrine is also good. It is being dosed in lower milligrams than it could be or that it is in other countries. Sudafed also brings a lot of worries for our diabetic hypertension patients and clearly children. So I think there are viable alternatives.

Mr. DAVIS. Yeah. But even so, it probably would still be receiving a great deal of consideration on the part of people who need it to make use of it.

And I guess for me, the good that it would do certainly outweighs whatever disadvantage it might cause. I mean, I for one would be prepared to support at this moment national legislation to—if we can reduce the number of labs that are being created, if we can prevent the kind of accidents that are occurring and taking place, and then the ultimate impact on the lives of the individuals who become addicted, then it seems to me that it is as clear as day that we need to move in the direction that you have suggested. And no matter what the opposition might be, you would certainly have one vote in the House of Representatives in favor. I thank you for your testimony.

And Mr. Chairman, I yield back.

Mr. GOWDY. I thank the gentleman from Illinois. The chair would now recognize himself for 5 minutes of questions.

I want to preface it by saying I want to play the devil's advocate, just because somebody is going to ask the questions, and we got to be prepared for it.

I will start with Mr. District Attorney, you had wonderful success in Oregon. The gentleman from Mississippi has outlined wonderful

success. You had no blowback from physicians, which is unusual, none from patients. Why have the 48 other States not followed suit?

Mr. BOVETT. I think this is in part, Mr. Chairman, alluded to earlier, the industry. The industry is very successful in lobbying and preventing this legislation from moving forward.

Mr. GOWDY. What argument do they use that is most compelling with State legislators in the face of the overwhelming evidence you and others outlined to the contrary?

Mr. BOVETT. Mr. Chairman, I think Kentucky is the perfect example, where they have had the electronic tracking system in place for the longest period of time, and it simply failed to deliver the promise to reduce meth labs or smurfing. It is an investigative tool, and that is all it is.

So the argument they make is one of patient access. The arguments they make are the parade of horribles that have been mentioned. All these bad things are going to happen. And in Kentucky, they actually set a new record, the State record for the amount spent on lobbying. And that doesn't even include their public campaign in terms of advertising. Massive amounts of money they spent to kill the bill in Kentucky this year. We simply can't compete with that.

Mr. GOWDY. Special Agent Dorsey, I want to lay aside OxyContin, Lortab, the pain treatments because I understand the point that Mr. Grellner and the district attorney made. But we have also prosecuted Phentermine and Fenfluramine, which are diet pills, that were entire cottage industries and still are around bariatric medicine for weight loss. What is to say that we won't have those same mills crop up when it comes to runny noses and sniffling, and instead of this panel of experts, we will have DEA diversion experts saying we need more help going after doctors who are essentially prescription mills?

Mr. DORSEY. Mr. Congressman, as you well know, drug addicts are quite creative. And there are opportunities and ways that they will go out there, and they will come up with techniques that will surprise you and I. But here is an opportunity to—it is an inconvenience. It will be an inconvenience. But what I would point to you is in my State alone, since NPLEx has been going on since January 1 of 2011, from the numbers we have been able to show, only approximately 15 percent of South Carolinians are buying this stuff, which surprised me.

Mr. GOWDY. Have you seen prosecutors who are willing to roll up smurfs in Title 21 conspiracies or whatever the State equivalent is in South Carolina?

Mr. DORSEY. I can't speak to the Federal side. I am aware of a State grand jury case in South Carolina that did that. The problem is that hole that you create from sending those people to prison fills up so fast. And so that is just not a practical solution, the prosecution of these people. Because again, for every person you put in prison, you are going to have 10 more to replace them.

Mr. GOWDY. I think they call it the hydra effect. All right.

I am going to do what I love do with law enforcement officers, which is talk philosophy. From a philosophical standpoint, the public is tired of having its behavior changed because a certain per-

centage of people just will not, cannot comply with the law. I doubt you all have worked very many or prosecuted very many arson cases that did not involve an accelerant, but there has been no discussion of scheduling gasoline or kerosene. You have never worked a bank robbery case where there was a demand note and anyone advocated that we do away with papers and pens. Or a stabbing that didn't involve a sharp edge. And I understand that these are somewhat absurd examples.

But nonetheless, there is a frustration within the public that it is always us that is inconvenienced because of the criminal element, while the criminal element, to your point, Agent Dorsey, is just going to find another way around it. So how do you strike the balance between—and you have convinced me. I was convinced before I got here; it is an epidemic. All the things that you all have said about methamphetamine times 10 are true. But how do you strike the balance with the law-abiding public versus the criminal element when it comes to placing barriers? And whoever has read Kant most recently can take a stab at it.

Mr. GRELLNER. Can I stake a stab at it for you?

Mr. GOWDY. Yes, sir.

Mr. GRELLNER. We are not inconveniencing a large amount of society. It is being inconvenienced already by the meth labs. A Rand study in 2007 said United States taxpayers in 2005, on the low end, spent $23.4 billion on the meth lab problem in the United States. We are all being impacted by it already.

When I look at the sales of pseudoephedrine in Oregon, a State of 3.9 million Americans, they are selling about 9,700 boxes of pseudoephedrine a month by prescription. When you come to the great State of Missouri and look at the tracking system, a State of 6 million people, that would mean we should sell about 15,000 boxes a month. We are selling between 120,000 and 165,000 boxes a month; 90 percent of these sales go directly diverted to methamphetamine laboratories. They are not being used. They are a commodity. When we have individuals standing on parking lots of pharmacies paying people $20 to go inside and buy pseudoephedrine to bring back outside so they can sell it to a meth lab for $100, it is not a commodity any more, sir, it is a currency.

Mr. GOWDY. All right. Last question because my time is up, and I know none of you are old enough to have been around in 1976 when the decision was made to take it from prescription to OTC.

Mr. BROOKS. I was.

Mr. GOWDY. Probably. By the looks, none of you were around. What was the argument made in 1976 of why we need to take this from prescription to OTC?

Mr. BOVETT. If I can answer that, Mr. Chairman.

Mr. GOWDY. Sure.

Mr. BOVETT. I have done an extensive study on the history of this, wrote a law review article about it, spent a lot of time on this.

This actually began in 1962 with a mandate from Congress to the FDA to study a broad spectrum of drugs to decide which drugs should be allowed to be sold over the counter as a modernization effort. It took them basically 14 years to get the monograph established for OTC cold and allergy medicines. And so they went through an analysis of what was safe and effective for use. And the

primary problem with that analysis is it looked at the drug itself for its intended purpose. It didn't look at the drug for its illicit purpose. So while the DEA and some at the DEA said, hey, we don't think you ought do this, they were looking just at the confines of the drug itself. Is it safe and effective?

Now, I actually have arguments—I would love to talk with the good doctor at some point—about why this drug should never have been moved from the schedule to OTC to begin with based upon its pharmacology, but that is a separate argument. I think that is the answer to your question.

Mr. GOWDY. With that, I will recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Chairman Gowdy.

And you know, the problem of meth in my State of Missouri is very troubling. In fact, Jefferson County, which is close to my district, has had by far the largest number of meth labs in the State. The meth problem is so pervasive that some people call it Metherson County.

Detective Sergeant Grellner, in Missouri meth is a formidable foe. And I appreciate your efforts to eradicate this menace from our State. And as president of the Missouri Narcotics Officers and as a narcotics unit commander, I know you have had specialized training. Could you detail for us training for law enforcement, the equipment necessary to uncover the clandestine meth labs and interact with children on the scene and handle those combustible products?

Mr. GRELLNER. Yes, sir. Thank you. First off, it takes four officers to do a methamphetamine laboratory and specialized training. It takes 48 hours of specialized training given to us by the DEA. So it takes them out of my office for a week to 2 weeks in Washington, D.C., at the DEA training academy. Once they come back to me, then we have to buy suits that cost up to $500 per suit to wear on the scene with the new flame retardant properties that they have. Special air-purifying respirators are necessary, as well as self-contained breathing apparatus and specialized air-monitoring units. Sitting on my parking lot right now is a $250,000 vehicle that we take to methamphetamine laboratory sites to fight meth labs. That money could have been better spent in the Department of Corrections working on the rehabilitation of individuals that are addicted to different drugs.

On top of that, when those four officers go out to the scene, they are photographed by the press and the media, and they can no longer work undercover on problems such as prescription drug abuse and heroin and cocaine. They spend several hours on the scene. Then they must transfer hats and become a hazardous waste company and clean up the hazardous waste that is left behind. They have to transport that to specialized buildings throughout the State of Missouri, where they must store the hazardous waste, categorize the hazardous waste and make it for pick up by the EPA. Then they have to write their reports and testify in court. Oklahoma did a study in their State that said one meth lab with conviction cost their State $350,000 per conviction.

Mr. CLAY. That really strains law enforcement budgets throughout the country, I am sure. Over 45 cities and towns in Missouri

require consumers to have a doctor's prescription to buy any form of pseudoephedrine. This applies to about 400 pharmacies and businesses. How effective have the local ordinances been in halting the sale of ephedrine or pseudoephedrine within the local communities?

Mr. GRELLNER. First, I am happy to report that that number has gone from 45 communities to 71. Almost 600 pharmacies now require a prescription in the State of Missouri. The State of Missouri also has a tracking system, fully implemented and been online since January 1, 2011. The State of Missouri realized a 6.8 percent increase in meth labs in 2011. However, the area in southeast Missouri bordering Kentucky and Tennessee, two other high States for meth labs, where most of these cities are located, saw a 52 percent drop in meth labs in their area in 1 year's time. And sales of pseudoephedrine are down from 165,000 boxes to 120,000 boxes in June of this year.

And when I have gone for the last 3 years to over 200 city and county council meetings, the question that I am asked by every committee, have you told this to the State government and have you told this to the Federal Government? Why haven't they taken care of the problem? Why do we at the city and county level have to take care of a problem that is a national problem?

Mr. CLAY. Mr. Brooks or anyone else on the panel, can you discuss the increase of meth use in urban and suburban areas?

Mr. BROOKS. Well, I think, you know, certainly we are seeing, and you have heard testimony on dramatic increases of meth use and meth labs. I think the problem we are dealing with here is really that domestic meth lab production problem. Because we are going to continue to get meth brought in from other source countries.

You know, so clearly the issue here is not as much about use, although it certainly is, it is more about reducing that dangerous toxic problem in our communities. Children in meth labs, toxic waste dumping into our waterways and into our communities, dangerous to first responders, police officers and other first responders that you heard Sergeant Grellner describe. I personally have held the hand of two friends as they died from cancer that were police officers that had worked in meth labs. And I have had countless other friends that are suffering from that. The impact on our community budgets.

And I will tell you the other thing, sir, the thing that is really tough right now, these are labor-intensive investigations. In California, we have had such dramatic cuts in budgets, we have now at least a 70 percent reduction in law enforcement resources to work drug crimes. Seventy percent fewer cops to work these drug crimes. And so when we start to see some reductions, I think part of why we see reductions is because we don't have anybody out there looking; we don't have anybody out there able to work these crimes. And California is not the only State in the Union that is cash strapped.

Clearly, if we are going to have an impact on environmental impact, on the drug-endangered children problem, on the danger to cops and firefighters, we are going to need to control pseudoephedrine.

Mr. CLAY. Thank you.

Mr. GOWDY. Thank the gentleman from Missouri.

With your indulgence, because we do have such a wonderful panel of witnesses, and this is such an important issue, if your time allows, we are going to perhaps go to what we call a second round or a lightning round. I will do my best to reduce the time to 3 minutes that we have from 5.

Are you all amenable to that? Will your schedules allow?

With that, I would recognize the doctor from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

And I think, as my good friend Chairman Gowdy said, we need to take advantage of the witnesses we have before us. Let's assume that what we have been talking about today happens, and we do pass a law that allows that this become a prescription or controlled substance. That is going to turn the attention back to the physicians, the prescribers, and the law enforcement. We were at a meth summit in Crossville, Tennessee, and had over 100 law enforcement agents. And I found it interesting that I quickly removed my congressional hat and put on my physician hat, because I felt there was a great disconnect between law enforcement and physicians. And we were talking more about narcotic drug abuse. But do you find that there is maybe poor communication between law enforcement and physicians? And if so, what can we do to improve that?

Mr. FISHER. If you don't mind, I will take that one. In our effort to schedule pseudoephedrine in Mississippi, I approached the Mississippi State Medical Association, the Board of Pharmacy, the Nursing Board, Board of Health. The Medical Association got on board with us. And now with the prescription drug abuse issue, we have the prescription drug monitoring program in Mississippi. And we are having a difficult time getting physicians to buy in to use the PDNP, if you will. Most of the States have it; some of them are in various forms. But one of the things that was useful with us with respect to scheduling pseudoephedrine is we have got a population of roughly 3 million, give or take a few there. There are somewhere north of between 500,000 and 550,000 prescriptions written on a monthly basis. Two-and-a-half to 3 percent at the highest is what we have seen with Sudafed prescriptions, and that is at the height of the cold and flu season. But what I have encouraged other law enforcement counterparts to do across the country is to establish those relationships with the medical community.

Mr. DESJARLAIS. I would just say we have an opportunity. Right now in Congress, we have a large number of physicians; we have a Physician Caucus with 20 members, over 600 years experience. And I can speak I think for 95-plus percent of physicians; there are bad apples in every profession, and you all know who they are. And through pain management clinics, there have been ways to skirt the rules and look legal even though we all know pill mills are out there. But I would encourage meetings with our caucus and ways to open those channels of communication. Because I can guarantee you physicians don't want to have to treat meth patients. They don't want to see these burn labs. And I think because of regulations, whether it is HIPAA or other compliance issues, there is some paranoia among physicians about what their rights are in

terms of reporting patients and using these databases. So that was the one thing we established that I think we are on—I know we are on the same team, the vast majority of us. And we need to find a better way to deal with this.

Mr. BOVETT. If I could add just briefly, Congressman, I would echo all of your sentiments and Marshall Fisher's as well. What happened in 2005 in Oregon is our physician community, our dental community, our nurses, our pharmacists were all part of the solution. And actually, they were some of the champions for it. What that has done is it has paid off in dividends subsequent to that because we now have—we didn't before have a working relationship or dialogue about things like prescription drug abuse, which we never had before. So, actually, we kind of came together to deal with meth labs. And we came away from that with friends and partnerships.

Mr. DESJARLAIS. Okay. I see my time has once again expired.

Thank you, Mr. Chairman.

Mr. GOWDY. It goes so quickly, doesn't it? Thank the gentleman from Tennessee.

We now recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

I guess my one question would be, how do we increase the collaboration between all of the components? As we have had this fight against proliferation of drug use, both prescription drugs, yes, there are people who abuse them, and abuse them greatly, but then it is the illegal drugs that we see that have taken such a drastic toll on our society as a whole. I come from an environment where our county jail can't keep the people who are picked up. Actually, we have more than 10,000 people. I think we have the largest county jail system and the largest unified court system in the country. And we are spending enormous amounts of money. How do we increase this collaboration between all components of the community to reduce our reliance upon drugs?

Mr. BOVETT. Congressman, very briefly, I can only speak from the Oregon experience, I saw that dramatic change occur in 2004 in Oregon because everybody was operating in their own silos. And what happened was our Governor had the foresight and wisdom to put us all in the same room. So he called together prevention, and treatment, and enforcement, and most importantly, the recovery community, and he said, come up with real solutions. And once we started working with each other and talking to each other, the amount we could accomplish together was phenomenally greater than the individual silos.

Mr. GRELLNER. Speaking from my task force, we are the first task force I know of in the country that in its own building incorporates prevention, enforcement, and rehabilitation. We understand to have that impact, you have to have all three working together. We hold NA and AA meetings at our building. We provide housing for the drug court participants. We provide training for the drug court participants. And we also allow training for prevention programs in the high schools and junior highs. You have to bring those three together like a three-legged stool.

Mr. DAVIS. I thank you very much.

Mr. DESJARLAIS. Would the gentleman yield?

Mr. DAVIS. Yes.

Mr. DESJARLAIS. Not to down downplay the impact of the illegal drugs, but I know someone on the panel wanted to say it. The rate of overdose from drugs is higher with controlled substances, prescription drugs, than it is illegal drugs. Is that the case?

Mr. BOVETT. Yes.

Mr. GRELLNER. Yes.

Mr. DESJARLAIS. Just to be aware of how severe that problem is.

Mr. DAVIS. Well, I appreciate your understanding of the entire system, and especially the whole question of recovery. I do something once a year called a recovery walk. And I usually have 300, 400 recovering individuals who might walk 2 or 3 miles, or whatever we decide. And I think the understanding that comprehensively is the only approach that really will work to reduce the dependence upon external substances. So I appreciate your testimony.

Mr. GOWDY. I thank the gentleman from Illinois.

I am going to continue with my trend of anticipating the defense argument.

There is a bill pending in Congress right now, Mr. District Attorney, dealing with copper theft, which is also an epidemic. And at first blush, you want to sign on to it because it is a horrible problem in South Carolina. I assume it is in other places, too. People disabling air conditioning, construction sites. But then you stop and think, well, if somebody goes to a neighborhood in Greenville or Spartanburg, South Carolina, and cuts the copper from an air conditioning units and then takes it to a scrap metal dealer, where is the interstate nexus? You saw the Supreme Court in Lopez, despite the fact that we don't want guns on schools, say that the Gun-Free School Zone Act was unconstitutional because there wasn't sufficient interstate nexus. You saw with Morrison, we all live with domestic violence, which is a horrific epidemic nationwide, and certainly in South Carolina. And in Morrison the Supreme Court struck down Congress' efforts to fix that, saying that it was not sufficiently nexused with interstate commerce. I understand the schedules are already Federal. If Congress passed something and gave the States an opt out, how many States would opt out? How many States are you having trouble not just persuading them that there is a problem, but how many States would affirmatively opt out if there were a Federal solution?

Mr. BOVETT. Mr. Chair, I am not exactly sure. I believe this is a Federal matter. It long has been a Federal matter. The schedules are controlled federally. So I think there frankly shouldn't be an opt out. Because the minute you have an opt out, you create a hole, you create a hole that basically bleeds out through the neighboring States. Because the pseudoephedrine in my State that is used to make the meth labs happen is from Washington, Idaho, and California. I don't want Washington opting out and electing to essentially subject me to what should be their meth labs. It doesn't make sense as a national policy to do an opt out.

I do understand your concern with the case law and the trends we have been moving forward. I think, again, looking at Oregon, back to your scrap metal example, we struggled for years mightily with that issue, until they finally got tired of it, and they came to me and I crafted up some legislation that so far has been working.

But it wasn't something that I could have got done in 2000. We had to go through about 10 years of trauma before we got to people willing to actually implement a real solution. And we have gone through 35 years of trauma when it comes to pseudoephedrine. It is past time to actually implement a real solution.

Mr. GOWDY. All right. Last question.

Our culture prefers prison; other cultures prefer other means of corrective measure. Have you ever made an effort to publicize the stores that are selling a disproportionate amount of ephedrine or pseudoephedrine, or name the pharmaceutical companies that are uncooperative?

Mr. GRELLNER. Yes, sir. I look at the—I pore over the files that come in from the database every month, and I post the top 30 stores in our State that are selling pseudoephedrine, which happen to be in the top 10 counties for meth labs. Right now, one corporation, one large chain store owns nine of the highest selling stores in the State out of the top 10. They own 17 out of the top 20. And they continue to sell. They sell cold packs that are used to manufacture meth in one pot bottles. They are an eight-pack box now, an eight-pack box of instant cold packs. And now can you buy one for $9.99 and get another one at 50 percent off. Who needs 16 instant cold packs? Someone who manufactures methamphetamine.

Mr. GOWDY. So if you were testifying at trial and I asked you in front of the jury whether or not you had exhausted every other means of combating this epidemic shy of scheduling ephedrine and pseudoephedrine, your answer would be?

Mr. GRELLNER. Yes, sir. I have worked on this problem and worked on legislation since 1999 and have been pushed back by industry every year with a solution that does not work. And I am baffled why legislators, when listening to officers on the street, don't believe us.

Mr. GOWDY. The chair would now recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman.

And Detective Grellner, along those same lines of questioning, what has been the response of the large retailers when you have brought the issue to them and had strong evidence that they were supplying this chain of meth manufacturing?

Mr. GRELLNER. I liken it to if a constituent called in and said that there was a man on the corner in your area selling 90 percent of the heroin in your area, you would expect law enforcement to go to that corner, immediately stop that man from doing that, incarcerate him, rehabilitate him, and take care of the problem. Our street corners in Missouri, especially in the St. Louis metropolitan area, are lined with big box pharmacy stores that are selling 90 percent of their pseudoephedrine diverted to methamphetamine laboratories hiding behind FDA rulings, their attorneys, and their lobbying efforts.

Mr. CLAY. Let me ask Mr. Bovett, I have a letter here from my local chapter of the NAACP. Let me share with you what they highlight: It is our firm belief that efforts to combat meth production should be focused on legislative solutions that target criminals, not law-abiding citizens. In the past, some lawmakers have advocated for a mandate that would force all consumers to obtain a doc-

tor's prescription before buying common cold and allergy medicines containing pseudoephedrine because some criminals misuse those medicines to make meth. We strongly oppose that approach. It would raise costs for thousands of St. Louis residents. Not only would a prescription requirement lead to additional copays and fuel costs, it would also result in lost wages for workers who are forced to take time off from work to visit a doctor.

What would be your response to the St. Louis chapter of the NAACP?

Mr. BOVETT. Congressman, I would say that I am a little bit surprised at that approach. I think they need to maybe do a little more research, find out what the real implications of doing this are. That sounds more like the pharmaceutical industry's parade of horribles. I would also encourage them to check with the California chapter of the NAACP, which actually testified literally right next to me in favor of Senate Bill 484 in California, which Mr. Brooks mentioned, saying that prevention is the correct approach, not arrest and incarceration.

And what we have before you here today is a pure prevention solution to the meth lab problem, because frankly, law enforcement does not want to track down, arrest, and incarcerate more smurfers and meth cooks. It is an endless supply. We want to actually prevent the problem.

So I would encourage your chapter of the NAACP to contact us, maybe do a little further research. I think they will realize what we are proposing is a prevention solution, and just the opposite of the criminalization approach that they are proposing.

Mr. CLAY. Thank you for that response.

Mr. GOWDY. I thank the gentleman from Missouri.

Again, on behalf of all of us, we cannot thank you enough for your time, for loaning us your expertise. I think you have convinced everyone, if they didn't already know that it is an epidemic, and we value your perspective, or at least I do very much.

So, with that, our committee would stand adjourned.

[The information follows:]

[Whereupon, at 11:29 a.m., the subcommittee was adjourned.]

SOUTH CAROLINA LAW ENFORCEMENT DIVISION

NIKKI R. HALEY
Governor

MARK A. KEEL
Chief

September 6, 2012

Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
2157 Rayburn House Office Building
Washington, DC 20515

Re: Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence

Dear Chairman Gowdy, Vice Chair Gosar, Ranking Member Davis, and Subcommittee Members Burton, Clay, DesJarlais, McHenry, Mica, Murphy, Norton, and Walsh,

This letter is in reply to your request for additional information regarding my testimony presented to the Committee on July 24, 2012. Listed below are the responses to your questions. I sincerely appreciate the opportunity to provide information to the Committee regarding this important issue. If you have any additional questions, please do not hesitate to contact me.

Questions and Responses

1. Please provide any data in your possession regarding South Carolina state and local law enforcement reporting of illnesses that are believed to be direct or indirect results of on-duty exposure to methamphetamine, methamphetamine laboratories, or chemicals or substances associated with the manufacture of methamphetamine.

The South Carolina Law Enforcement Division ("SLED") is not in possession of quantitative data nor do we currently collect quantitative data that completely and accurately reflects all reporting of illnesses of law enforcement officers in South Carolina that are believed to be associated with exposure to methamphetamine, methamphetamine laboratories, or chemicals associated with the manufacture of methamphetamine. However, SLED is aware that many police officers throughout the State have been exposed to harmful elements from meth lab manufacturing sites. These exposure incidences include, but are not limited to, the exposure to ammonia and iodine

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crystals, the exposure to hypodermic needles, and numerous cases of heat exhaustion, most of which have required medical care.

2. Please provide any data in your possession regarding South Carolina state and local law enforcement reporting of costs associated with on-duty exposure to methamphetamine, methamphetamine laboratories, or chemicals or substances associated with the manufacture of methamphetamine, including costs for medical treatment (whether active duty or retired) and related litigation.

SLED is not in possession of data that completely and accurately reflects all reporting of costs associated with on-duty exposure to methamphetamine, methamphetamine laboratories, or chemicals associated with the manufacture of methamphetamine. However, SLED has been notified by a sheriff's office in South Carolina that a recent meth lab exposure to a law enforcement officer resulted in an emergency room visit that cost the County approximately $4,500.00 in medical bills.

3. What is the average number of labor hours required for South Carolina state and local law enforcement to seize, process, and clean a methamphetamine laboratory site upon discovery?

The resource requirements to seize, process, and dismantle a methamphetamine laboratory vary greatly and are primarily contingent upon the size of the laboratory. A law enforcement officer in South Carolina averages five to six hours of labor to seize, process, dismantle, and clean equipment upon the discovery of a methamphetamine laboratory site.

4. How much time over the course of a year (in both raw labor hours and percentage of total hours) does South Carolina state and local law enforcement dedicate to methamphetamine laboratory seizure and cleanup?

The resources dedicated to methamphetamine laboratory seizures and the removal of gross contaminants vary across South Carolina and is contingent upon the amount of methamphetamine labs discovered in a particular jurisdiction. Some law enforcement agencies have a dedicated unit that solely focuses their enforcement efforts on searching and dismantling methamphetamine labs. Other jurisdictions are not in a position to have such a specialized unit due to their limited financial resources. SLED recently requested information from sixteen (16) local law enforcement agencies in South Carolina regarding this question. Listed below are all responses received by SLED:

<u>Responses Received</u>
Lexington County Sheriff's Office (Narcotics Unit) – 50%
York County Drug Enforcement Unit – 96 hours / 5%
Pickens County Sheriff's Office (Narcotics Unit) – 50 hours / 3%
Dorchester County Sheriff's Office (Narcotics Unit) – 25%
Chesterfield County Sheriff's Office (Narcotics Unit) – 100 hours
Newberry County Sheriff's Office (Narcotics Unit) – 100 hours

Aiken County Sheriff's Office (Narcotics Unit) – 780 hours per investigator
Horry County Drug Enforcement Unit – 250-350 hours

Essentially, this data clearly indicates that local law enforcement officers are spending a significant amount of labor, time, and resources on meth lab seizure and cleanup within their jurisdictions, particularly in areas of the State where the impact of methamphetamine is greater {*see attached Maps (2) - Meth Labs in South Carolina*}.

5. What is the average cost for the cleanup and/or remediation (i.e. longer-term rehabilitation, beyond basic cleanup) of one methamphetamine laboratory site in the State of South Carolina? Where possible, please provide details about the breakdown of overall costs.

According to the SLED Drug Lab Cleanup Program ("DLCP") which tracks meth lab data reported to SLED, the average cost for the cleanup of a methamphetamine laboratory site in South Carolina is $2,400.00. This cost solely reflects the price associated with the removal of gross contaminants by a hazardous waste removal contractor and does not include the remediation of the property. In South Carolina, the remediation of the property is the responsibility of the property owner. SLED does not have data available to provide an accurate representation of the hedonic costs of meth lab seizures such as costs to fire and other emergency responders, equipment costs for state and local governments, property devaluation, environmental destruction, and negative social impact.

6. Does the State of South Carolina classify a methamphetamine laboratory site as a hazardous material (or "hazmat") site?

When hazardous materials are located at methamphetamine laboratory sites, they are removed from the area by a hazardous waste contractor and disposed of in compliance to legal requirements. There is no regulation in South Carolina that requires the property to maintain a state-designated "hazardous material site" label.

7. If the State of South Carolina does classify a methamphetamine laboratory site as a hazmat site, does that also mean that state and local law enforcement agencies can seek funding from the state government for methamphetamine laboratory site cleanup and/or remediation?

Currently, SLED pays for costs associated with the removal of gross contaminants from methamphetamine laboratory sites when requested by law enforcement agencies in South Carolina. However, local law enforcement agencies incur additional costs resulting from lab seizures (personnel overtime, material processing, etc.).

8. Does SLED (or other state and local law enforcement agencies) consider so-called one-pot or shake-and-bake methamphetamine laboratories to be less of a public safety hazard than traditional, larger methamphetamine laboratories?

The one-pot methamphetamine laboratories are a greater risk to public safety than traditional meth labs due to easy lab mobility, the amateur manufacturing competence of one-pot meth lab operators, and the simple availability of precursor chemicals.

Lab Mobility and Amateur Manufacturing

The convenience of a one-pot lab allows for the easy transport of highly explosive chemicals in inexpensive, low quality containers. These small labs are highly mobile and can be relocated without creating suspicion from the average person. South Carolina law enforcement officers have found one-pot labs in vehicles, boats, drainage ditches, homes, and hotels. In fact, Sheriff's Investigators in Greenville, South Carolina recently located a one-pot lab in the bathroom of a retail pharmacy[1]. In many cases, officers have also found that more experienced methamphetamine manufacturers that manage larger labs have been replaced by one-pot manufacturers who attempt to make meth with amateur manufacturing competencies compared to that of the larger lab operators. SLED believes this shift in meth manufacturing operations creates a greater public safety hazard because limited manufacturing competencies often directly correlate with an increased chance of a lab explosion.

Availability of precursor chemicals

Despite many legislative attempts to prevent meth precursor chemicals from entering the illicit marketplace, manufacturers have usurped regulations through the practice of smurfing. Smurfing occurs when a criminal misrepresents himself or herself to a retailer with the intent of collecting precursor chemicals for the sole purpose of manufacturing methamphetamine. Current regulations and the NPLEx tracking system relies on the assumption that criminals will be honest in representing their true identity to retail outlets as they make purchases of precursor chemicals found in common cold medicines. However, criminals often steal identities or subvert regulations and NPLEx by misrepresenting themselves or using the purchase limits of other criminals to collect a surplus amount of precursors to manufacture meth. Because of this common smurfing practice due to the unfortunate limitation of current regulations and the NPLEx tracking system, precursor chemicals are readily available to criminals.

9. What is SLED's (or other state and local law enforcement agencies') perspective of the precursor tracking system(s) currently in use in the State of South Carolina?

The National Precursor Log Exchange ("NPLEx") was implemented in South Carolina on January 1, 2011, and provides law enforcement with an investigative tool to identify persons who purchase unusually high amounts of EPH/PSE products. NPLEx is useful to law enforcement by:

a) Providing officers with the ability to identify persons who purchase unusually high amounts of ephedrine/pseudoephedrine (EPH/PSE) based products;
b) Providing officers with the ability to gather information about past purchases of EPH/PSE after an arrest is made to gather historical evidence for a subject's prosecution.

The intent of NPLEx was to better electronically track EPH/PSE purchases through a central, interlinking database. Despite the good intentions of NPLEx to better track and limit illicit

[1] Fox Carolina News website. http://www.foxcarolina.com/story/19124868/non-active-meth-lab-found-at-greenville-pharmacy. Accessed September 6, 2012.

EPH/PSE purchases, it has not stopped domestic meth manufacturing in South Carolina. NPLEx is not limiting illicit purchases. In fact, in the first year of utilizing NPLEx, South Carolina actually saw an increase in discovered meth labs. According to data maintained by SLED, since February of 2012, only ten percent of the meth lab seizures by law enforcement in South Carolina were the result of the use of NPLEx.

Despite the implementation of NPLEx, South Carolina has not seen a decrease in meth production. Instead, we have experienced the exact opposite. Domestic meth manufacturing is increasing in South Carolina and will likely continue to increase unless Congress enacts targeted legislation to combat our nation's meth epidemic.

The current NPLEx tracking system has not been effective in reducing domestic meth production in South Carolina. It does not effectively identify illicit purchases of precursor chemicals, it does not successfully limit illegal EPH/PSE purchases being diverted to meth manufacturing, and it is not a comprehensive tool to truly combat the meth lab epidemic. As discussed in the previous answer, NPLEx relies on the assumption that criminals will be truthful in representing themselves to retailers as they make purchases. However, identity fraud and collective smurfing completely negates the potential value of the system.

10. Does SLED (or other state and local law enforcement agencies) regard its precursor tracking system(s) as effective in slowing, halting, or disrupting methamphetamine laboratories and/or production in the State of South Carolina?

As stated in the previous answer, SLED does not believe the NPLEx System is an effective remedy for slowing, halting, or disrupting methamphetamine laboratories and/or production in the State of South Carolina. Even NPLEx blatantly admits that the real-time reporting of EPH/PSE transactions can only "...potentially prevent(ing) the manufacturing of methamphetamine."[2]

11. What problems or difficulties, if any, have South Carolina law enforcement reported in using its precursor tracking system(s)?

[2] NPLEx Website. http://www.nplexservice.com/faq.html Accessed September 6, 2012.

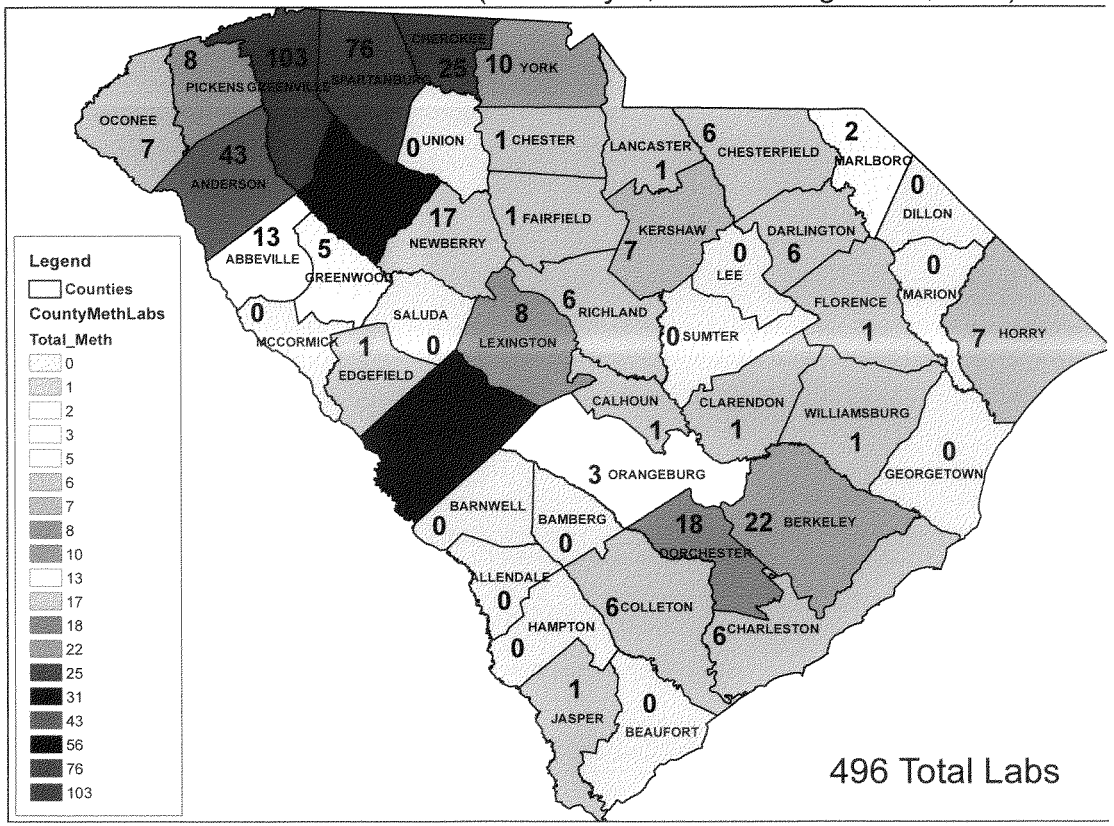
To date, SLED has not received any reports regarding problems or difficulties associated with the use of the NPLEx System in South Carolina.

Respectfully submitted,

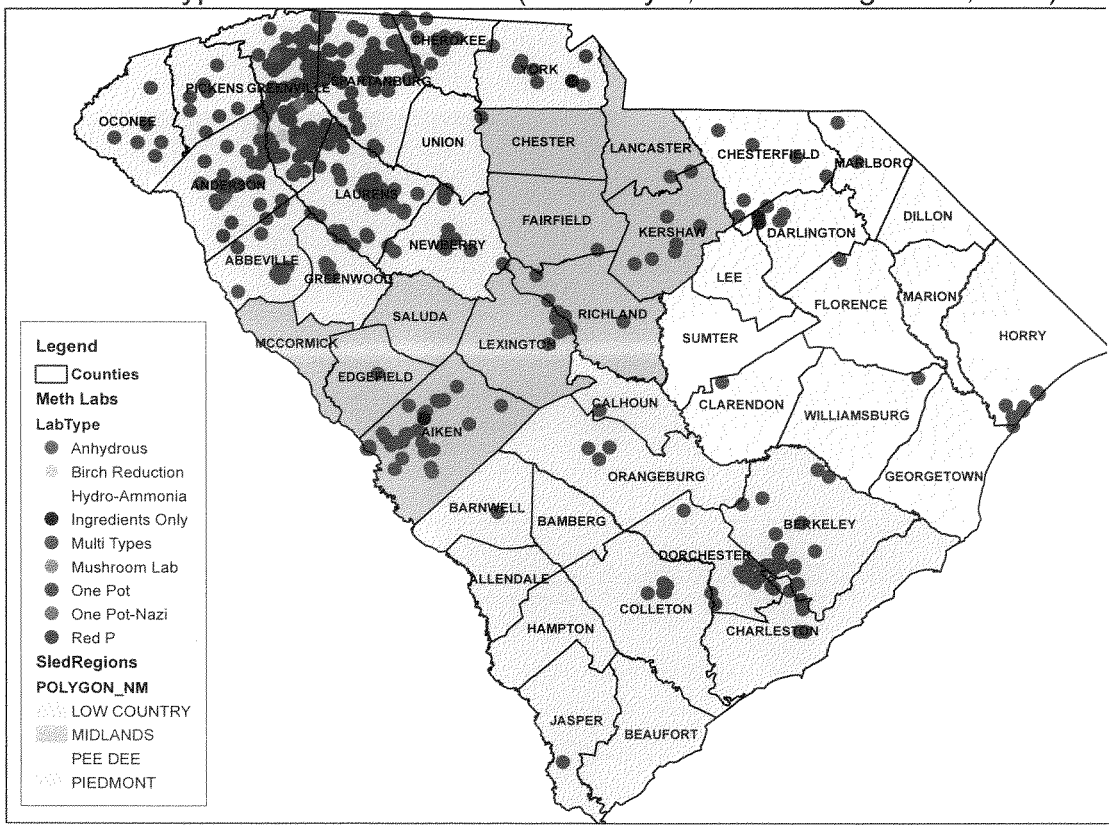
SC LAW ENFORCEMENT DIVISION

D. Max Dorsey, II
Lieutenant

Meth Labs in South Carolina (from July 1, 2011 to August 31,2012)



Meth Lab Types in South Carolina (from July 1, 2011 to August 31,2012)



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Pennsylvania Narcotic Officers' Assn.
Puerto Rico Narcotic Officers' Assn. (TEDE)
R.I.S.S. Project
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September 17, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
United States House of Representatives
Washington, DC 20515

RE: Responses to Questions for the Record – Methamphetamine Hearing

Dear Chairman Gowdy,

Per your letter dated August 23, 2012, below are responses to three questions pertaining to the July 24, 2012 hearing "Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence."

1. *"Please provide any data in NNOAC's possession regarding federal, state, and local law enforcement reporting of illnesses that are believed to be direct or indirect results of on-duty exposure to methamphetamine, methamphetamine laboratories, or chemicals or substances associated with the manufacture of methamphetamine."*

   - To my knowledge there is no single repository of data regarding law enforcement illnesses related to meth or meth lab exposure. It is also difficult to definitively link specific diagnoses to exposure to chemicals present at clandestine meth labs. Our information is anecdotal, and given time constraints, it is not possible to present a complete picture of the nationwide impact of meth-related exposure on law enforcement officers.
   - Personally, I have dealt with the health issues experienced by some of my best friends as a result of meth lab exposure. In fact, I have

delivered eulogies at the funerals of two friends who developed cancers and died prematurely. Dale Switzer, my former partner at the Redwood City, CA police department, died in 2006 from a rare saliva duct cancer that was attributed to his years of exposure to meth labs dating back to the 1980s. Just last year, Rick Oules, another long time partner at the California Bureau of Narcotic Enforcement, and former Director of the Division of Law Enforcement at the California Department of Justice, died from lung and other cancers that were attributed to years of exposure to meth labs.

- Below are just a few of many other examples around the nation of dedicated law enforcement officers who suffered as a result of exposure to meth labs:
    - A Deputy Sheriff in Ohio was assigned to meth lab enforcement in 2004 and developed neurological issues which his doctors attributed to exposure to chemicals at clandestine labs. He was forced to leave his job with a permanent disability retirement.
    - A Special Agent with the Bureau of Narcotic Enforcement (BNE) in the California Department of Justice died in 2007 from cancer attributed to exposure to carcinogens while investigating clandestine meth labs.
    - A Provo, Utah police officer died of kidney cancer at age 36 in 2005 and his doctors attributed his cancer to repeated exposure to chemicals at clandestine meth labs.
    - A California BNE Special Agent who spent three years assigned to clandestine meth lab enforcement succumbed in 1998 to cancer attributed to exposure to meth lab chemicals.
    - A Deputy Sheriff in Perry County Ohio was exposed to concentrated anhydrous ammonia gas at a clandestine meth lab in 2010, suffered severe respiratory issues and was forced to leave his job with a disability retirement.
    - A police detective in Midvale, Utah died from an aggressive form of esophageal cancer that was attributed to his exposure to clandestine meth labs.

2. *"Please provide any data in NNOAC's possession regarding federal, state, and local law enforcement reporting of costs associated with on-duty exposure to methamphetamine, including costs for medical treatment (whether active duty or retired) and related litigation."*

- We do not have reliable data or estimates of the aggregate or average cost of treatment for law enforcement personnel who have been exposed to meth labs while on duty. Estimates of the costs of methamphetamine to society in general have been developed (most notably in a 2005 RAND study), and elements of the overall cost include the cost to treat public safety professionals who have been injured in the line of duty.

3. *"Has NNOAC received any input from federal, state, or local law enforcement officers or agencies (formally or informally) about technical, logistical, or other problems with the tracking systems currently in use at the state level?"*

- Several states who have implemented tracking systems report that the systems do not stop sales destined for clandestine meth labs. Retail stores often say they are blocking sales, but the sales volume continues to be high, and overall sales volume for PSE products has been shown to not be reduced. Smurfers often use fake IDs to get around the system.
- As I noted in my written statement for the record, Kentucky was the first state to implement a tracking system. Every year since the implementation, the number of lab incidents in Kentucky has gone up. Tracking is a reactive meth investigation technique that is labor-intensive. In today's budget environment relatively few agencies have the law enforcement resources to effectively use tracking to impact the meth problem. A typical "smurfing" investigation requires two uniformed officers and four detectives, with roughly an eight-hour detail for each of those six officers. The typical result of the investigation is two or three smurfers arrested, and possibly a meth lab discovery.
- Our members have found that cooks are putting a broker between themselves and the smurfers to isolate and protect the lab operations, further weakening any defenses against PSE diversion that tracking systems are supposed to provide.

Thank you for the opportunity to provide testimony to the subcommittee on this critical issue. Please let me know if you have any additional questions.

Sincerely,

Ronald E. Brooks
President
National Narcotic Officers' Associations' Coalition (NNOAC)

STATE OF MISSISSIPPI

DEPARTMENT OF PUBLIC SAFETY
MISSISSIPPI BUREAU OF NARCOTICS

ALBERT SANTA CRUZ
COMMISSIONER

PHIL BRYANT
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September 5, 2012

Committee on Oversight and Government Reform
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Also sent via e-mail (in MS Word format) to:
Will Boyington at Will.Boyington@mail.house.gov

Dear Chair Gowdy, Vice-Chair Gosar, Ranking Member Davis, and Subcommittee Members Burton, Clay, Desjarlais, McHenry, Mica Murphy, Norton, and Walsh,

This letter is in response to Chairman Gowdy's letter dated August 23, 2012, asking for answers to two supplemental questions arising out of the hearing on July 24, 2012, entitled "Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence." I have recited each of the questions below, followed by my response.

1. Has the State of Mississippi seen reductions in direct and/or indirect costs associated with methamphetamine laboratories in the two years since Mississippi re-scheduled ephedrine and pseudoephedrine in 2010? If possible, please provide details about such cost increases or decreases since 2010, and include a discussion of costs of Drug Endangered Children (DEC) related serviced, hospital burn unit services, agricultural anhydrous ammonia leak and/or exposure events, and methamphetamine laboratory cleanup and/or remediation.

The State of Mississippi has seen significant reductions in costs associated with methamphetamine labs. For example a comparison of operational Mississippi labs seized in the first quarter of 2010 and the first quarter of 2012 indicate a 93% reduction. During the first quarter of 2010, 147 operational meth labs were seized. In the first quarter of 2012, 10 operational labs were seized.

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If the cleanup cost per lab averages $2500, the costs to cleanup 147 labs is approximately $367,500.00. The cleanup cost for 10 labs is approximately $25,000.00. These savings to the taxpayer are obvious. It would be difficult to figure how many man hours are saved as a result of the effect of this legislation, however, state narcotics agents are now focused on investigating drug trafficking organizations instead of focusing on "user" labs operated by addicts. In calendar year 2010, 138 drug endangered children were removed from hazardous sites. Comparatively only 23 drug endangered children have been removed from hazardous sites during calendar year 2012. Unfortunately, we do not have actual cost comparisons for savings to the taxpayers regarding drug endangered children. I don't really believe we can actually measure the tremendous cost of human misery and suffering of the innocent monetarily. As to the anhydrous ammonia issue, this simply has not been a factor in Mississippi in the last 7 plus years. I do not have any raw data regarding hospital burn units. Mississippi currently has only one inpatient burn center, Crossgates River Oaks Hospital located in Brandon, Mississippi. River Oaks burn center is affiliated with the Joseph M. Still Burn Center in Augusta, Georgia. After speaking recently to the CEO of River Oaks, he indicated that he had no current raw data but has noticed a drastic reduction in admissions since the passage of Mississippi's PSE prescription law in 2010.

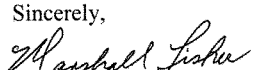
2. To the extent that methamphetamine laboratories are still being discovered within the State of Mississippi, can Mississippi state and local law enforcement confirm the origin or source of the precursor materials used in these laboratories?

We are very happy to report that since Mississippi's 2010 House Bill 512 went into effect in July 2010 our methamphetamine related incidents are down 72% and our actual operational methamphetamine labs are down 95%. Mississippi has experienced no tsunami of "doctor shopping" for PSE and no "smurfing" of PSE. We have had two reports in two plus years of some prescription PSE bottles seized at lab sites. Officers and agents routinely determine that the PSE utilized at labs seized in Mississippi comes from one of our four bordering states. Arkansas has for the most part voluntarily stopped selling PSE over the counter to Mississippi residents. Recently, Louisiana has reached out to our agency for assistance in presenting similar legislation in its state.

Additionally, pursuant to 2012 legislation passed in Alabama, residents of Mississippi and Oregon are required to furnish a prescription in order to obtain PSE in Alabama. In 2009, Mississippi had 348 operational labs. In 2010, the number of labs reduced to 314, and in 2011 the number of labs further reduced to 155. For the present year, Mississippi has seized 18 operational labs. The following numerical data supports the total methamphetamine related incidents: 2009=691, 2010=698, 2011=330, and 2012=198. The numbers speak for themselves.

If I can be of any further assistance, please don't hesitate to contact me.

Sincerely,



Director Marshall Fisher
Mississippi Bureau of Narcotics

SEP 2 0 2012

Sir,

Let me once again thank you for your attention to this matter, and for allowing me to testify before you in July. I hope the following information, as well as my verbal testimony, helps you and your colleagues to truly understand the depth of the methamphetamine manufacturing problem, and the simple solution. I will do my best to answer the questions which you posed, and I'm also enclosing two other documents which I hope will further complete your understanding of the local and national threat that the clandestine methamphetamine manufacturing process poses to all US citizens. After 22 years of law enforcement service I understand that many crimes do not have a solution, but I know that this one does. In this situation, the clandestine manufacture of methamphetamine, the United States cannot point a finger at an outside country as the cause of its narcotics woes. This problem is being inflicted on the US population by criminals operating in this country and I believe being aided by our own pharmaceutical industry. By controlling the sale of pseudoephedrine by prescription, access to the main ingredient needed for this heinous crime will be taken away from criminals and still allow access to those who may need this treatment. Once again thank you, and your committees' commitment to reviewing state and national drug control policies surrounding this issue, and seeking to find a solution.

In reference to the questions submitted in your mailing I will attempt to answer each one in numerical order. In reference to question one regarding data of law enforcement officers injured as a result of exposure to clandestine meth lab chemicals, I have no formal data in my possession. What I can tell you is very personal. In June of 2002 while investigating the third meth lab of a 26 hour shift I was exposed to and overcome by a chemical, anhydrous ammonia, which is commonly found in many Midwestern meth labs. The acute symptoms of this exposure caused immediate nosebleed, shortness of breath, and blistering of my mouth and throat. The long-term effects have been the loss of 27% of my total lung volume, chronic lung disease, and a shortening of my life. As bad as that may seem what bothers me more is the effects these labs have had on the men and women who work with, and for me. In November of 2011 one of my agents was operated on for torn shoulder ligaments after loading unapproved cylinders containing anhydrous ammonia, from meth labs into pickup trucks for disposal. After the surgery the officer was off duty for four months rehabilitating his shoulder and will never have full mobility as before the accident. In December of 2012 another of my officers was diagnosed with kidney cancer. This agent has spent many years combating and investigating meth labs and had no other

health issues prior to this disease. He leads a healthy lifestyle, is physically fit and has no family history for cancer. The week before Christmas one of his kidneys was removed and he was out of work for two months. For the next five years, every three months he has multiple scans of his body and doctors examinations for fear that this cancer will recur in other parts of his body. Finally, in May of 2012 one of my agents came ill and had trouble breathing during. His diagnosis it was found that a fist size tumor had grown between his heart and lung in 18 months time. This agent was on medical leave for three months after the surgery was performed to remove the tumor from his chest. The one thing that all of these agents have in common is the 100+ meth labs that we work together each year.

I know an officer from St. Louis County Missouri who also suffered lung function loss after exposure to meth lab chemicals. I testified in his civil action against the property owners where the lab had been located. I'm aware of three officers from Clay County Missouri who have also been affected by the inhalation of meth lab chemicals. As I speak and teach throughout Missouri I am constantly sought out by individuals in the crowd who either personally experienced adverse health effects or know of officers from their own departments who have been affected by meth lab chemicals. As each of these incidents are treated as workers compensation cases I know of no formal database or recordkeeping in Missouri that details these incidents.

In reference to question number two I have no data regarding medical treatment costs or litigation of officers throughout the state of Missouri. What I can provide you with, once again, is my own experience. Medications to treat my disease cost in excess of $300 per month. Hospitalization occurs on average 1 to 2 times per year, and during acute disease times other medications are necessary, outside of my daily routine, which costs hundreds of dollars more. Current litigation with worker compensation professionals involving my long-term health costs, which are estimated in the neighborhood of $500,000. Civil litigation was brought against the individual who was ultimately federally convicted in the case in which my injury occurred. Although that litigation found damages in my behalf of $5 million I've never collected a penny. The defendant has spent many years in federal penitentiaries and the insurance companies fought and won appeals as to their liabilities in the case.

Question number three is a question that has been posed to Missouri law enforcement many times. Answering this question is not easy, and must take into account numerous tasks which must be undertaken by agents before, during, and after the locating of the lab. Other external factors affecting the amount of time spent on each case include, but are not limited to; the amount of chemicals found on scene, the number of suspects located during the investigation, the number of minor children involved in the case and whether state or federal prosecution is called for in each case. EPA and OSHA require at least four lab qualified investigators on the scene of any clandestine methamphetamine lab incident. Lab qualified investigators are individuals who have taken at least 40 hours of extra training in the identification and handling of hazardous waste. In most cases agents will spend between two and four hours on the scene of an average meth lab. Many lab sites have needed as long as 8 to 12 hours of on scene investigation. In Missouri the job of handling the hazardous waste does not stop at the scene. Missouri's use of its hazardous waste bunker system in response to its overwhelming clandestine meth lab problem, means many more hours on the job for investigators. Agents must classify all hazardous waste on the site, appropriately package it, safely haul it, and then properly store it at one of 26 bunker

locations throughout the state of Missouri. Many of these bunker locations are on law enforcement property and require these agencies to expend additional man-hours in the proper running and auditing of these hazardous waste facilities. Evidence samples must be properly overpacked before shipment to overworked crime laboratories in Missouri where analysis wait times have been as long as 12 months. If children are involved in the case extra man-hours are required to deal with Missouri Division of Family Services, foster care services and Family Court appearances. I have personally sat with children in emergency rooms for 6 to 8 hours while they are medically examined for any adverse effects of living in homes with meth labs. Investigators time is also spent on report writing, grand jury testimony, preliminary hearings, and finally court cases. As you can see it is very hard to find a quantifiable number on the amount of hours spent on each of Missouri's 2000 to 3000 meth labs per year. The common cry from law enforcement commanders throughout the state of Missouri is that these labs cripple manpower resources, and devastate overtime budgets.

Question four again is very hard to answer. In the hardest hit meth lab areas of Missouri 1/3 to 1/2 of all narcotics cases involve meth labs. Other areas of the state, where prescription only ordinances have been enacted, have seen dramatic decreases in lab rates. In those areas man-hours would be much lower. Trying to calculate raw labor hours or a percentage of total hours is well outside my statistical ability.

In calculating the average cost for cleanup and/or remediation in question five many options must be considered in each case. First and foremost there is a distinct difference between clean up and remediation. Cleanup is the action of trained law enforcement removing gross contaminants and hazardous material from the scene of clandestine methamphetamine lab incident. Remediation is the removal of all chemical hazards to acceptable levels on the entire property by a trained hazardous waste cleaning company. On average the cost of disposal of chemicals for Missouri meth labs cost approximately $500 per incident. This cost does not include man-hours for retrieval, transportation, or storage of these chemicals prior to pick up by a hazardous waste disposal company. These costs are handled by the agencies investigating the labs and operating hazardous waste bunkers at their facilities. Cost for a full remediation of properties is very dependent upon the size of the property. Average costs in our area are between $10,000 and $30,000 per property. Most of the time these costs are not covered by homeowners insurance or renters insurance, as these are considered criminal acts and outside the scope of the insurance company's liability.

In reference to question six, the State of Missouri under Department of Natural Resources guidelines classifies all clandestine lab sites as hazardous waste sites. Each site must be documented and all applicable forms must accompany hazardous waste removed from those scenes. All investigators entering upon those scenes must be properly trained at the level of hazardous waste technicians and their training must be up-to-date.

Although each clandestine methamphetamine laboratory location is identified as a hazardous waste site in the state of Missouri it does not qualify for any special funding, either state or federal, for the cleanup of that location. In reference to question seven local agencies cannot seek any relief for money spent investigating the scenes or for the handling of the hazardous waste located.

Question number eight's comparison, of the new "shake and bake" method of manufacturing, versus prior recipes used for the conversion of pseudoephedrine into methamphetamine is well warranted. Although earlier manufacturing styles used larger quantities of chemicals to convert larger quantities of pseudoephedrine into methamphetamine, the new manufacturing process is much more dangerous. In the old processes each part of the chemical conversions were kept separate, and although each had its dangers it was a much more controllable chemical process. Accidents did occur, and fires and explosions were investigated but not on the level we are seeing today. Although the new conversion method uses much smaller quantities of chemicals, multiple chemical processes are ongoing at the same time in one vessel and many of these processes are incompatible with each other. Fires and explosions from this new process are inevitable. Criminals can follow the recipe with no mistakes, and still have an uncontrollable fire or explosion occur. This hazard is easily identified by the number of individuals being treated in burn units throughout Missouri and the Midwestern United States from "one pot" meth labs. Also, because the size of the vessels containing the chemical reaction has gone from 2 L bottles to 20 ounce bottles, these labs are much more portable. Active meth labs have been found in shopping carts and purses in three different Walmart stores throughout this country. Explosions and fires are occurring in vehicles operating at 70 miles an hour on interstate highways, causing danger not only to the occupants of the vehicle, but the motoring public at large.

The precursor tracking database referenced in question nine is of no use in the prevention of meth labs in Missouri or any other state. The database is a tool used by law enforcement in the investigation of a crime that has already occurred. The database tracks sales that have all ready been made, and the crime occurs at the time of that sale. Although the database blocks sales at 3.6 g per day and 9 g per month in Missouri, it does nothing to block meth labs. These blocked sales only slow criminals who have lost count of the 3 or 4 boxes they had already purchased that month and converted to methamphetamine. Law enforcement in Missouri use other databases to investigate crimes to include fingerprint and DNA databases. The theory that precursor tracking databases will prevent meth labs is like saying that fingerprint databases will prevent robberies and burglaries, and that DNA databases will end homicides and sexual assaults. This is why in every state where electronic precursor tracking databases have been employed meth lab incidents have increased not decreased. It is the goal of Missouri law enforcement to end meth labs, not to locate more meth lab incidents and arrest more Missouri citizens.

The other unintended consequence of the precursor tracking database is the proliferation of the black market on cold tablets containing pseudoephedrine hydrochloride. Boxes of cold tablets in the Metropolitan St. Louis area now sell on the black market for anywhere from $65-$105 per box. This black market is causing a completely opposite reaction, in that it is inviting more individuals into criminal activity. In this economy anyone wishing to make 600 to 1000% interest in a matter of minutes need only invest in cold tablets. Profits from the black market sale of the pseudoephedrine tablets are also being used to enhance our prescription drug abuse and illegal heroin narcotics trade. The precursor tracking database as referenced in question 10 has had no effect on slowing, halting, or disrupting methamphetamine laboratories, or its production in the state of Missouri. Between 2010 and 2011 Missouri saw an increase in the total number of clandestine meth lab incidents by almost 7%. The precursor tracking database was fully functional throughout the entire 2011 calendar year. A 12 County area in southeastern Missouri saw a 52% drop in meth lab incidents during the same.

time period. This drop was attributed to the fact that all of the counties and cities in that area had adopted ordinances requiring a prescription for pseudoephedrine. It is quite obvious from those statistics alone that the precursor tracking databases have no effect on clandestine lab incidents, and although proponents may say that it helps investigators locate and prosecute suspects they are not the ones paying for said prosecution, rehabilitation and incarceration.

Finally two of the most glaring problems referenced in question 11 are; the use of multiple identifications and the fact of Missouri having six year valid drivers licenses. Many of the criminals involved in illegal narcotics activities are quite transient. Many of them don't stay in the same location for longer than six months, let alone six years. Although the database may be able to identify the individual purchasing the pseudoephedrine, it does not help in locating the purchaser or in locating pills after their purchase and who reduced them into methamphetamine. We have also seen the use of fake and multiple identifications by individuals attempting to circumvent the database. If this database could identify fake or altered identifications I'm sure it would be employed by the alcohol dispensing industry in an attempt to stop minors from purchasing alcohol. The precursor tracking database, which is paid for by the same industry that manufactures the products being traced, has never, and will never lower clandestine methamphetamine lab incidents. It was the pharmaceutical industry's way of diverting legislators attention away from the real problem, which is the diversion of 90% of the industry pseudoephedrine to the manufacture of methamphetamine.

Once again, thank you for your service to our country, and your review of this very important law enforcement issue. I'm attaching two documents for your review, one of which is statistical data from Missouri, and the other is a PowerPoint presentation comparing Missouri and other Midwestern states in their two decade fight against the clandestine manufacture of methamphetamine.

Respectfully submitted,

Detective Sgt. Jason J Grellner

President Missouri Narcotics Officers Association

SEP 1 2 2012

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Victim Services Supervisor

September 4, 2012

Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
2157 Rayburn House Office Building
Washington, DC 20515

Also sent via e-mail (in MS Word format) to:
Will Boyington at Will.Boyington@mail.house.gov

Dear Chair Gowdy, Vice-Chair Gosar, Ranking Member Davis, and Subcommittee Members Burton, Clay, Desjarlais, McHenry, Mica, Murphy, Norton, and Walsh,

This letter is in response to Chairman Gowdy's letter dated August 23, 2012, asking for answers to two supplemental questions arising out of the hearing on July 24, 2012, entitled "Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence." I have recited each of the questions below, followed by my response.

1. Has the State of Oregon seen reductions in direct and/or indirect costs associated with methamphetamine laboratories in the six years since Oregon re-scheduled ephedrine and pseudoephedrine in 2006? If possible, please provide details about such cost increases or decreases since 2006, and include a discussion of costs of Drug Endangered Children (DEC) related services, hospital burn unit services, agricultural anhydrous ammonia leak and/or exposure events, and methamphetamine laboratory cleanup and/or remediation.

The State of Oregon has certainly seen reductions in direct and indirect costs associated with domestic meth labs in the six years since we returned ephedrine and pseudoephedrine (PSE) to scheduled prescription drugs in 2006. However, providing details of such reductions is not possible, due to the context in which our law was enacted in 2005.

Oregon's law returning PSE to a prescription drug was passed prior to the current economic recession, and the resulting severe budget cuts at both state and local levels. Thus, while budget savings can always be a strong motivating factor, the primary driver of our legislation in 2005 was the public health and safety benefits of getting rid of meth labs, not cost savings. As a result, we did not, and have not, analyzed our cost savings.[1]

That being said, it is worth noting that the economic costs of domestic meth labs have been analyzed in other contexts, at least in part, albeit not specifically in regard to Oregon cost savings. Two are worth a brief mention:

(a) Oklahoma: Nearly a decade ago, John Duncan, PhD, of the Oklahoma Bureau of Narcotics (OBN), attempted to calculate the total average socio-economic impact of one domestic meth lab, extrapolating that lab to an average meth cook, and typical behaviors, over the course of a year, and their primary and secondary impacts on the system, and on others. Ultimately, Dr Duncan concluded that he could not determine a precise number, due to certain unknowable costs. However, Dr Duncan did reach the following conclusions and "unknowns:"[2]

Court	$5,000
Corrections	$252,000
Law enforcement	$5,000
Toxic waste cleanup	$3,500
Property damage	$17,000
Jobs	$50,000
Child welfare	$12,000
Mental health	$20,000
Treatment	$54,000
Health care	Unknown
Children	Unknown
School	Unknown
Family	Unknown
TOTAL:	$350,000

[1] At the request of our colleagues in California, Oregon did analyze and report the cost increase to our Medicaid program, which turns out to be less than $8,000 per year. A copy of that letter can be found here: http://www.oregondec.org/CSPSC/012b-DHS.pdf

[2] A slide summarizing the analysis by Dr Duncan can be found here: http://www.kynarc.org/sites/default/themes/knoaTheme3/images/cost.png

(b) California: In 2009, the California Bureau of Narcotics Enforcement (BNE) was tasked with analyzing the potential costs savings that might occur if the California Legislature enacted Senate Bill 484, legislation that would have returned PSE to a prescription drug in that state. Like the Oklahoma analysis, the California analysis was confined to cost savings in categories that could be ascertained, and further confined to cost savings that benefitted government (i.e., not cost savings for property owners and other third parties negatively impacted by meth labs). As with the Oklahoma analysis, the unavoidable conclusion is that millions of dollars in savings would occur by returning PSE to a prescription drug.[3]

2. To the extent that methamphetamine laboratories are still being discovered within the State of Oregon, can Oregon state and local law enforcement confirm the origin or source of the precursor materials used in these laboratories?

Thankfully, I can answer at least one of your two supplemental questions. Since we returned PSE to a prescription drug, Oregon has experienced no PSE "smurfing" and very few meth lab incidents.[4] However, we have consistently asked our responding law enforcement officers to actively seek to determine the source of PSE, in cases where that can be determined. In every case where a determination can be made, the PSE was smurfed from neighboring states, mostly Washington, but also Idaho, California, and, in one instance, Nevada. Furthermore, there have been no incidents where the PSE was prescription PSE (i.e., PSE obtained here in Oregon).

As always, please don't hesitate to contact me if I can be of any further assistance, and I look forward to working with you on this issue in the future.

Sincerely,

Rob Bovett
District Attorney, Lincoln County, Oregon
Legal Counsel, Oregon Narcotics Enforcement Association

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[3] A copy of the full report from BNE can be found here:
http://www.oregondec.org/CASB484/SB484-Savings.pdf

[4] A graph of Oregon meth lab incident trends can be found here:
http://www.oregondec.org/OregonMethLabTrends.pdf

The Alabama Law Enforcement Advocacy Group

The Honorable Trey Gowdy

Chairman - Subcommittee on Health Care, District of Columbia, Census, and the National Archives

Committee on Oversight and Government Reform

U.S. House of Representatives

2157 Rayburn House Office Building

Washington, DC 20515

Greetings,

The Alabama Law Enforcement Advocacy Group was formed to speak on behalf of all law enforcement throughout the state of Alabama. Our mission is to advocate for the safety and welfare of peace officers as well as the safety and security of the citizens we are sworn to protect. Generally, we do not get involved in political debates. However, the scheduling of pseudoephedrine is a tremendous concern for the safety of law enforcement, and our citizens.

With the scheduling of pseudoephedrine, the number of clandestine methamphetamine labs will dramatically fall. This fact is proven in the drop in clandestine labs in Mississippi and Oregon. What is not often discussed in the pseudoephedrine debate is the **cost** in incarceration, prosecution, cleanup, and most importantly lives. According to the Alabama Sentencing Commission Report of 2012, on February 6, 2012, there were 924 inmates incarcerated for Manufacturing of a Controlled Substance. What is the cost of incarceration alone? According to the Alabama Department of Corrections, in 2009 the cost to house an inmate was $15,118.30 a year. That is nearly $14 million just to house those incarcerated! The number of seized clandestine have varied and is debatable. However, by making pseudoephedrine prescription only will only reduce the number.

With each clandestine lab, our peace officers are exposed to toxic fumes and hazardous wastes. But there are also children, other family members, cleanup crews, and other neighbors that are exposed, or may be exposed, to these hazards. What is the cost per cleanup? According to DEA cleanups are $2,000-$3,000 per lab. Alabama has had as many as a thousand clandestine labs in a year (according to figures compiled by the DOJ funded drug task forces). This amounts to a figure of at least an additional $2 million a year for cleanups alone.

This brings us to a total of approximately $16 million a year (for Alabama) in costs related to clandestine methamphetamine labs. This is without the costs of prosecution, medical treatment for exposure, or most importantly the children exposed. All of this can be cured by pseudoephedrine being made prescription only. Scheduling works, just ask Mississippi and Oregon, they prove it.

Thank you for your time and consideration.

Respectfully submitted,

The Alabama Law Enforcement Advocacy Group
Jim Henderson - Director
July 30, 2012

July 27, 2012

The Honorable Trey Gowdy
Chairman – Subcommittee on Healthcare
District of Columbia – Census and National Archives
Committee on Oversight and Government Reform
US House of Representatives
Washington, DC 20515

RE: Pseudoephedrine Controls to Reduce Methamphetamine Labs

Dear Mr. Chairman:

As the Director of the Appalachia HIDTA, covering the states of Kentucky, Tennessee, Virginia and West Virginia, I strongly support the return of pseudoephedrine (PSE) to prescription drug status.

In my particular area, one of our biggest threats is locally produced methamphetamine. Local production most often consists of small laboratories set up by methamphetamine users who obtain pseudoephedrine, one of the necessary precursors, from over-the-counter cold medications. The threat and dangers posed by clandestine methamphetamine labs in the Appalachia requires immediate and effective action. It is very clear to me, and to my Executive Board, that the successes of Oregon and Mississippi in drastically reducing the number of meth labs in those states can be replicated nation-wide by implementing prescription only PSE on a national basis.

Law enforcement in my area does not, and will not, have the resources to track down "smurfers", and the continued increase in small toxic labs in much of the country clearly illustrates that computer tracking systems have had no impact in reducing meth labs. The only logical answer to reducing meth labs and the associated damage – both human and environmental – is to once again make PSE a prescription drug.

Sincerely,

Joe Williams
Director

PO BOX 5070 ♦ LONDON, KY 40745
PHONE: (606) 877-2100 ♦ FAX: (606) 862-8143

Designated and Funded by the Office of National Drug Control Policy

ATLANTA HIDTA

July 26th, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Mr. Chairman:

As the director of the Atlanta High Intensity Drug Trafficking Area (HIDTA), I am writing to thank you and your committee for your important focus on the scourge of methamphetamine and your consideration of legislation requiring a physician's prescription for the purchase of pseudoephedrine.

The Atlanta HIDTA covers areas of Georgia, North Carolina and South Carolina and this year we are seeing unprecedented levels of lab seizures. Many of these involve small levels of production through what is commonly called "the one pot method". Tracking systems in each of the three States are not proving an effective deterrent to the groups of purchasers called "smurfs." They travel across State lines, and use numerous altered and fictitious identification documents to avoid apprehension. We are becoming increasingly aware that what may appear as a legitimate purchase in a tracking system is in fact recorded to a false or altered name. We are also very aware of the limitations where a system in one State has no communication with its neighboring States.

Methamphetamine is universally recognized as one of the most destructive drugs for its users. Its manufacture poses immediate health, safety, and environmental concerns. Costs for cleaning up after production are running at tens of millions of dollars annually. Now, we are also facing the cumulative effect on our communities of small, easily thrown aside, one pot labs.

763 Juniper Street
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Designated and Funded by the Office of National Drug Control Policy

ATLANTA HIDTA

At the same time, we see the effectiveness of laws in Oregon and Mississippi and in individual cities and counties in Missouri that require a physician's prescription for the purchase of the essential raw material found in these labs, pseudoephedrine.

It seems that the choices on this are very clear. We can chase the distribution of pseudoephedrine for illicit purposes, inefficiently and at a high cost, or we can stop it, while still maintaining availability to patients who require it.

We appreciate your leadership and the Committee's willingness to look at this issue with the clear focus you did in recent direct testimony.

Sincerely yours,

John C. Killorin
Director

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678-244-8400

OFFICE OF THE SHERIFF

BUTTE-SILVER BOW LAW ENFORCEMENT DEPARTMENT

225 ALASKA STREET

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July 27, 2012

The Honorable Trey Gowdy, Chairman
Sub-Committee on Healthcare, District of Columbia, Census
and the National Archives Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Re: Pseudoephedrine Prescription-Only Legislation

Chairman Gowdy:

As Sheriff of Butte Silver Bow County, Butte, Montana, I strongly support the idea of having all Pseudoephedrine medications available by prescription only. In our state, we've seen quite a reduction in having the Pseudoephedrine medications taken off the retail shelves and placed behind the counter of the pharmacies, but that hasn't completely eliminated the issue.

I feel that if we were to follow the lead of the State of Oregon and have a prescription-only request for Pseudoephedrine, we would be that much more able to control the issue of methamphetamine in our community, our state, and possibly nationally.

I believe this is a way to reduce the overall addiction to methamphetamine and I strongly encourage you to get this legislation passed if possible. I believe thousands of lives could be helped with this legislation.

Respectfully,

John P. Walsh, Sheriff
Butte Silver Bow Law Enforcement Dept.
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Butte, Montana, 59701
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JPW/cle

Central Florida HIDTA
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The Honorable Trey Gowdy
20515 Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC

July 26, 2012

Mr. Chairman:

The Central Florida area, like many other parts of the United States, is plagued with illicit methamphetamine production. Our eight (8) county area dismantled in excess of two hundred (200) meth labs in 2011. While our meth labs are small in size, producing less than two (2) ounces per cycle, they continue to pose health and safety hazards such as fire, explosions, and hazardous waste, to name a few.

These labs are all dependent upon the availability of pseudoephedrine (PSE). The movement of those products containing PSE behind the counter was very successful for a period of time and the number of labs greatly decreased. But, as is the case when dealing with individuals trafficking in illegal/illicit substances, given time, they will adjust and find a way. The adjustment we have observed in Central Florida is a more widespread and sophisticated effort at "smurfing". I'm sure you are aware that "smurfing" is several people obtaining those products containing PSE or possibly one person obtaining those products from several locations. Recently we have seen the recruitment and payment of large numbers of persons for the sole purpose of buying those cold/allergy products containing PSE. Many of these persons are not meth users they are simply "making a buck".

The states of Oregon and Mississippi have enacted legislation to further control those medicines containing PSE. Their rescheduling of pseudoephedrine and prescription purchase requirement has greatly reduced the number of labs in those areas.

I would very much like to see federal legislation requiring a prescription to purchase those medicines containing pseudoephedrine. I have no doubt this legislation would have a resounding positive impact on our national meth problem.

Respectfully,

William T. Fernandez
Central Florida HIDTA
Director

Central Valley California HIDTA
P.O. Box 2768
Rancho Cordova, CA 95741

July 26th, 2012

The Honorable Trey Gowdy
U.S. House of Representatives
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
2157 Rayburn House of Office Building
Washington, D.C. 20515

Dear Chairman Gowdy:

As Director of the Central Valley High Intensity Drug Trafficking Area (CV HIDTA), I am pleased to write this letter of support to voice my strong support for federal legislation to require a prescription for products containing pseudoephedrine (PSE). The Central Valley HIDTA established in 1999, consists of investigative task forces in 11 counties. Our area of California has been identified as the "Meth Capital" of the United States due to the high number of super labs.

Counties in the CV HIDTA were responsible for nearly half of all reported laboratory events (dumpsites, lab seizures and chemical or equipment seizures) in the entire State of California during 2011. In 2011, the CV HIDTA reported five super laboratories. A super lab is where 10 pounds or more of meth are produced in a single production cycle. This is why this region has large organized smurfing operations termed Super Smurfing because our laboratories require vast amounts of Pseudoephedrine that is unfortunately all too easily obtained by criminals.

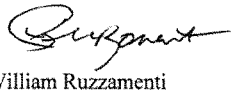
In recent years the states of Oregon and Mississippi have enacted legislation and ordinances restricting the purchases of precursor chemicals needed for methamphetamine production. This type of legislation has had a profound impact on the number of labs in these two states.

Recently the State of California eliminated the Bureau of Narcotics Enforcement; the Agency responsible for the majority of the lab clean-ups in California. This has placed an undue burden on the local agencies that are already stretched thin. Evaluating the results seen in Oregon and Mississippi shows the impact of rescheduling PSE to a prescription drug. These results give a compelling argument for rescheduling PSE. This type of legislation would greatly assist law enforcement agencies in the "Meth Capital."

I believe that legislation modeled after Oregon legislation requiring a physician's prescription to purchase pseudoephedrine would greatly reduce the number of methamphetamine labs seen by law enforcement agencies all over the United States. Thank you for your leadership on the Subcommittee and I strongly urge you to enact a law regulating the sale of pseudoephedrine based products.

Please don't hesitate to call me if you have any questions.

Respectfully,



William Ruzzamenti
Director

Room 104
Jackson County Courthouse
Altus, Oklahoma 73521
Telephone: (580) 482-5334
Fax: (580) 482-5346

FIRST ASSISTANT:
KEN DARBY

ASSISTANTS:
STEPHEN BOOKER
DAVID THOMAS

JOHN M. WAMPLER
DISTRICT ATTORNEY
THIRD JUDICIAL DISTRICT

DISTRICT THREE DRUG TASK FORCE

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman,

As Drug Task Force Supervisor for the District Three Drug and Violent Crimes Task Force and a member of the Executive Board representing the 19 State Drug Task Forces, One of our problems within my specific five county area and within the state of Oklahoma is the illegal manufacturing of meth/amphetamine. In past legislation Oklahoma implemented the PSE program that regulates the purchase of pseudoephedrine , the main precursor chemical in the manufacturing of meth/amphetamine. The PSE program initially slowed down the clandestine manufacturing of meth within our state. As time has progressed the meth cooks have learned how to circumvent the PSE program by using multiple forms of identification or having multiple persons purchase pseudoephedrine legally and later sell or give it to meth cooks to manufacture into meth/amphetamine. This is commonly referred to as "smurfing" Without a doubt, Oklahoma is besieged by small "shake and bake" meth labs, which are fueled by pseudoephedrine purchased **legally** by individuals who travel from store to store to obtain this requisite precursor to meth production. These "Shake and Bake" meth labs endanger the residents of the State of Oklahoma during the manufacturing process and also place a huge financial burden on the State of Oklahoma when law enforcement officers have to clean up these clandestine meth labs sites.

In this past legislative session, a bill was introduced in our state which would make pseudoephedrine a "prescription only" drug, however it failed to pass. The drug task forces of the State of Oklahoma need your help to regulate pseudoephedrine. Since Arkansas passed a law regulating pseudoephedrine by making the pharmacist the gatekeeper, and several municipalities in Missouri are requiring a prescription, the traffic at our pharmacies in Eastern Oklahoma has

increased tremendously. People are flocking from Arkansas , Texas and Missouri to Oklahoma in order to obtain their pseudoephedrine to manufacture meth.

We urge the passage of a bill that mandates that pseudoephedrine products be regulated and be made available by prescription only.

Thank you,

Bob Carder
Drug Task Force Supervisor
District Three Drug and Violent Crimes Task Force

TO: The Honorable Trey Gowdy 07/26/12
Chairman
Subcommittee on Health Care, District of Columbia,
Census, and National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

From: Sergeant Wayne H. Stinnett
Claremore Police Department
Investigations Division
200 W. 1st Street
Claremore, Ok 74017

Dear Sir,

I am writing in regards to the proposed control of products containing pseudo-ephedrine. As I'm sure you're aware ephedrine or pseudo-ephedrine is the base element in the manufacture of methamphetamine. The methamphetamine epidemic being experienced in our country has destroyed innumerable lives and created untold millions of dollars of damage to property. I am the Sergeant for the Investigations Division of the Claremore Police Department. I am also the son of a life long law enforcement officer and one of my younger brothers is a police officer for the Tulsa Police Department. I have been in law enforcement for 25 years and in my experience I have never seen a drug that has a more devastating affect on families and lives than methamphetamine. This drug is a demon that destroys everything it touches. Lives are lost or destroyed, families are torn apart, potential is lost, and few recover or are saved from the destruction it creates. My brothers and sisters in law enforcement and I have sacrificed time, money, and in too many cases their health and even their lives battling this menace. This problem is so obviously out of control and the police officers across this nation are continuing to fight an uphill battle in the attempt to protect law-abiding citizens from those individuals who not only participate in the clandestine manufacture of this drug, but also from those who decide to abuse this illicit drug as well. I have participated in hundreds of investigations involving the manufacture of methamphetamine. These investigations have involved different manufacturing processes, but the common denominator in each of these cases is that they have all included the use of ephedrine or pseudo-ephedrine as a precursor to the manufacture of methamphetamine.

In 2004 Oklahoma lead the nation in the fight against the manufacture of methamphetamine by being the first state in the country to enact legislation to remove pseudo-ephedrine products from selves of pharmacies and department stores. This legislation requires that individuals present a photo-ID and actually sign for the purchase of these products. The resulting reduction in the seizures of clandestine methamphetamine laboratories in Oklahoma was noteworthy to say the least, proving the validity of the legislation.

Even though I was proud to be part of that effort our legislation fell short of providing the additional level of protection to our citizens by not requiring that a prescription be obtained from a physician prior to being able to purchase any product containing pseudo-ephedrine. An unforeseen result of this action was the creation of an additional level of criminal in the process of manufacturing methamphetamine who have become known as "smurfs." These individuals provide a service to methamphetamine manufacturers by purchasing pseudo-ephedrine products. These products are then sold to manufacturers either for cash or for a portion of the methamphetamine produced.

These issues could be resolved or reduced in quantity and intensity by the simple act of requiring individuals who purchase products containing pseudo-ephedrine to obtain a prescription from a physician. This action would have a direct effect on the amount of methamphetamine being manufactured in this country, and consequently the availability of domestically produced methamphetamine. This would also largely eliminate the "smurf" element as well.

Another resulting benefit of this action would be the reduction of the astronomical expenditures of the state and federal governments in the clean up of these clandestine methamphetamine laboratories.

This does not even begin to address the number of lives and families saved by the resulting reduction of the availability of methamphetamine.

Restricting the access to pseudo-ephedrine has been the only tested and proven truly effective deterrent to the methamphetamine manufacturing. Please give this proposal the consideration it is due. The resulting inconvenience to individuals who would be forced obtain a prescription for the legitimate use of these products is a small consequence when measured against the sacrifices made by so many in my profession or against the lives and families that could be saved or spared the destructive potential of this drug.

Sincerely,

Sgt. Wayne H. Stinnett
Investigations Division
Claremore Police Department

LLOYD WINNECKE
MAYOR

MIKE CONNELLY
FIRE CHIEF

550 S.E. Eighth St. · Evansville, IN 47713-1786
(812) 436-4413 · FAX: (812) 436-5758 · TDD/Hearing Impaired: (812) 436-4925

7/27/2012

The Honorable Trey Gowdy, Chairman
Subcommittee on Health Care, District of Columbia, Census and the National Archives
Committee on
Oversight and Government Reform
US House of Representatives
2157 Rayburn House Office Building
Washington DC 20515

Dear Honorable Representative Gowdy,

It is the goal of the Evansville Fire Department to minimize risks that face our community. The current drought conditions, amalgamated with individuals addicted to methamphetamine, warrant unprecedented emergency safety measures. By analogy, we have a conflagration of devastation to our local economy due to use of this illegal drug. Devastation due to: fractured families, meth lab explosions, physical dependence, cleanup costs, injuries and death. We as a community need to utilize all resources available to reduce the occurrence of methamphetamine use in our neighborhoods. Right now our resources are one step behind in the battle against controlling the damage this specific drug has caused. When methamphetamine use is eradicated from our city, only then can we use those resources for progress and growth, rather than damage control.

Our organization supports a prescription-only policy for PSE products. This letter is written in support of legislation to enact such laws; a key element in the elimination of methamphetamine in our community.

Thank you for consideration in this very important matter.

Sincerely,

The Evansville Fire Department

Mike Connelly

Mike Connelly
Fire Chief

Houston HIDTA
15311 Vantage Pkwy W
Suite 286
Houston TX 77032
(281) 372-5857

Aransas County
Brooks County
Fort Bend County
Galveston County
Hardin County
Harris County
Jefferson County
Jim Wells County
Kenedy County
Kleberg County
Liberty County
Montgomery County
Nueces County
Orange County
Refugio County
San Patricio County
Victoria County

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

As the Director of the Houston High Intensity Drug Trafficking Area (HIDTA), I am respectfully writing this letter to express my support for federal legislation to require a prescription for products containing pseudoephedrine (PSE).

The HIDTA Program is a unique partnership between federal, state and local law enforcement agencies that leverage existing resources to combat the most pressing drug threat in the region. Houston HIDTA consists of seventeen (17) counties in Texas that are along the Gulf Coast of Texas from the Louisiana State line to the counties just above Brownsville, Texas. Houston HIDTA was one of the original five (5) HIDTAs that began in 1991. One of the predominant threats in the Houston HIDTA counties is locally produced methamphetamine. Local production is often small clandestine laboratories set up by methamphetamine users who obtain PSE, one of the necessary precursor ingredients, from over the counter cold medication. The threat and dangers posed by clandestine methamphetamine labs in the Houston HIDTA counties requires immediate and effective action.

Unfortunately, most efforts to control access to PSE through log books and sale limits, which are requirements contained in the 2006 Combat Methamphetamine Epidemic Act, have proven ineffective. Methamphetamine producers are able to circumvent existing restrictions through the use of false identifications, organized "smurfing" rings and retail employee collusion. I believe that a national law requiring a physician's prescription to purchase pseudoephedrine would greatly reduce the number of clandestine methamphetamine labs and their inherent dangers throughout the United States.

Sincerely,

Michael McDaniel
Director
Houston HIDTA

Gulf Coast
High Intensity Drug Trafficking Area

3838 N. Causeway Blvd · Suite 1900 · Metairie, Louisiana 70002 · Phone (504) 840-1400 · Fax (504) 840-1406

July 26, 2012

The Honorable Trey Gowdy
Chairman, Subcommittee on Health Care, District of Columbia, Census, and National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
Washington, DC 20515

Re: Pseudoephedrine Controls to Reduce Methamphetamine Laboratories

Dear Mr. Chairman,

As Executive Director of the Gulf Coast High Intensity Drug Trafficking Area, which encompasses 26 designated counties in the five-state area of AL, AR, LA, MS and TN, I strongly support legislation making Pseudoephedrine (PSE) a prescription drug.

I have seen first-hand the positive results obtained by controlling PSE to require a prescription for the drug. In 2010, the State of Mississippi enacted H.B. 512 which made PSE a controlled substance requiring a prescription. Since then, the number of illicit meth labs in the state has dropped precipitously. More importantly, child endangerment incidents as a result of exposure to meth labs have abated as well.

Since enactment of the Mississippi law, surrounding states saw an increase in the number MS residents entering their states to obtain PSE-laced products. To combat PSE smurfing by MS residents, this year the State of Alabama passed H.B. 363 prohibiting the sale of products containing PSE to residents of states requiring prescriptions for the drug. Consequently, a nationwide law requiring prescription for PSE is needed.

Many alternative over-the-counter medications are available to consumers which are safe, effective and do not contain PSE. For those left that feel PSE is their best alternative, I say go see your doctor just as one would for any other malady.

In closing, I hope Congress acts swiftly to require a prescription for PSE.

Sincerely,

Anthony Soto
Executive Director

KENTUCKY NARCOTIC
OFFICERS' ASSOCIATION

Byron W. Smoot
President
Lexington Division of Police

Thomas M. Loving
Executive Director
Bowling Green - Warren County Drug Task Force

Victor L. Brown
Immediate Past President
Appalachia HIDTA

Mike Brackett
1st Vice President
Jefferson County Sheriff's Office

Dan Smoot
2nd Vice President
Operation UNITE

John Williams
Treasurer
Kentucky State Police
West Drug Enforcement Branch

Stanley W. Salyards
Secretary
Louisville Metro Police Department
Retired

Richard Badaracco
Sergeant at Arms
Drug Enforcement Administration, Retired

Marie Allen
Executive Board Member
Kentucky Alcoholic Beverage Control

Mark Burden
Executive Board Member
Kentucky State Police

Robbie Clark
Executive Board Member
Lake Cumberland Area Drug Task Force

Steven Cobb
Executive Board Member
Lexington Division of Police

Thomas Gorman
Executive Board Member
Drug Enforcement Administration

Christopher Watkins
Executive Board Member
Owensboro Police Department

July 27, 2012

The Honorable Trey Gowdy
United States House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Gowdy:

On December 7, 2009, the Kentucky Narcotics Officers Association (KNOA), representing over 300 narcotics officers throughout Kentucky, voted unanimously to approve and support the designation of pseudoephedrine (PSE) as a scheduled (prescription) drug. The membership believes this action is the most effective means to combat increasing clandestine methamphetamine laboratories (meth labs).

In the late 1990's, the Commonwealth of Kentucky began to experience an increase of illegal clandestine methamphetamine labs throughout the state. The numbers steadily increased until peaking in 2004/2005. In June 2005, a newly created Kentucky statute required that pseudoephedrine (PSE), the prime ingredient in illegally produced methamphetamine, be sold only from licensed pharmacies and that each sale must require a photo identification card from the purchaser and be recorded in a log subject to inspection by law enforcement. The "pharmacy log" statute had the immediate effect of substantially reducing clandestine meth labs in the state. Kentucky clan lab numbers went from 600 in 2004 to 302 in 2007, a decrease of nearly 50 percent. Throughout 2006 and the first half of calendar year 2007 the number of clan labs continued to show a decrease. However, this downward trend gave way to increasing monthly totals in the second half of 2007, resulting in a year-end total of 302 clan labs.

On June 1, 2008, in an effort to further reduce clandestine lab production, Kentucky law required the pharmacy logs to be reported on an electronic recordkeeping mechanism prescribed by state government. The Kentucky electronic tracking system (Meth Check/NPLEx) is accessible to Kentucky law enforcement agencies for tracking the sales of PSE. However, despite the new electronic tracking system, Kentucky's 2008 clan lab response numbers rose to 428, up from 302 in 2007, an increase of 41 percent. In 2009, Kentucky experienced a 74 percent increase over 2008, with a total of 743 clan lab incidents. Clan lab response continues to increase with 1,060 in 2010 and 1,201 in 2011. In its first year of operation, June 2008 through May 2009, the electronic tracking system blocked 18,000 sales of pseudoephedrine. However, the electronic tracking system had basically no impact on the number of labs in Kentucky. We have been able to establish that only 52 of the 743meth labs in 2009 were found due to our electronic tracking. We further believe that the large increase in meth labs located was not due to electronic tracking as some would have you believe.

There are two predominant factors contributing to the proliferation of Kentucky meth labs. The first is that many individuals and organized groups developed methods to circumvent the pharmacy log and electronic tracking system laws through actions that allow them to acquire PSE products in excess of legal limits. Law enforcement refers to this technique of multiple PSE purchases as "smurfing." The second factor is that a substantial number of clan lab cookers are now using the

429½ East 10th Avenue, Suite 1 • Bowling Green, KY 42101-2211 • www.kynarc.org
Phone (270) 843-5343 • Fax (270) 843-5347

"one pot" or "shake and bake" method to produce small amounts of the illegal drug. This is a very quick and very dangerous production technique that usually yields less than two ounces of finished product. It allows the cook to generate methamphetamine without requiring the purchase of PSE product amounts in excess of legal purchasing limits or triggering a blocked sale.

By contrast, in 2006, the state of Oregon enacted a law requiring a prescription for all PSE products. Oregon's clan lab response numbers went from 472 in 2004 to 10 in 2011, a 98 percent decrease. Now we have additional data from Mississippi the second state to require prescription only with a 70+ percent decrease in clan lab response. Based on the information and data available from Kentucky and other states, the Kentucky Narcotic Officers' Association (KNOA) considers Oregon and Mississippi's model the only method to significantly and lastingly reduce the number of meth labs. Meth labs cost the citizens of Kentucky millions of dollars in law enforcement and emergency services response time, hazardous waste clean up and disposal, social services, prosecution and incarceration. Meth labs are increasingly found in apartment buildings, hotels, rental property and near schools. Meth labs impact innocent bystanders to a much greater degree than any other illegal drug.

The KNOA is a non-profit organization of drug law enforcement officers from numerous city, county, federal and state law enforcement agencies across the Commonwealth. KNOA is a professional organization dedicated to enhancing the safety and security of Kentucky's communities through the education, training and professionalization of the men and women involved in investigating drug crimes throughout the state. We are not alone in our belief as reflected in the partial list of public service organizations that support scheduling of pseudoephedrine in Kentucky:

1. Kentucky Narcotics Officers' Association
2. Kentucky Association Chiefs of Police
3. Kentucky Commonwealth Attorneys Association
4. Kentucky Medical Association
5. Kentucky Academy for Family Physicians
6. Kentucky Chapter of the American Academy of Pediatrics
7. Kentucky Board of Pharmacy
8. Kentucky Education Association
9. Kentucky Association of Counties
10. Kentucky Hospital Association
11. Kentucky Agency for Substance Abuse Policy
12. Kentucky State Police
13. Appalachia HIDTA Drug Task Forces
14. Operation UNITE Drug Task Force (Original Pilot Project for MethCheck)
15. Bowling Green – Warren County Drug Task Force
16. Bowling Green Police Department
17. Owensboro Police Department
18. Warren County Sheriff's Office (Sheriff Gaines Named National Sheriff of the Year by NSA)
19. Lexington Metro Division of Police
20. Louisville Metro Police
21. Louisville Metro Health Department
22. Louisville Metro Board of Health
23. Louisville Fire Department
24. Louisville E.M.S.
25. Northern Kentucky Drug Strike Force
26. Shively Police Department
27. Greater Louisville Medical Society Public Safety Committee
28. West Jefferson County Community Task Force
29. Lake Cumberland Area Drug Task Force
30. South Central Kentucky Area Drug Task Force

KNOA is asking for your support in taking this issue to the United States Congress. Our goal in this effort is to educate lawmakers and others like you about the extraordinary costs to health and public safety in the United States. Meth lab incidents are rapidly increasing. These labs continue to be an impending threat to the health, physical safety and environment of our neighborhoods. With the number of unlawful pseudoephedrine shoppers in Kentucky estimated to be in the thousands, law enforcement's duty to intervene effectively in the illegal purchasing process is insurmountable. We believe that the best solution to combat this alarming threat is to make pseudoephedrine available only by prescription.

If you require additional information, have questions, or want to know how you can help, please contact KNOA Executive Director Tommy Loving at (270) 843-5343 or KNOA President Byron Smoot at (859) 576-3706.

Sincerely,

Byron Smoot, President

Indiana Drug Enforcement Association

The Honorable Trey Gowdy,
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman,

I would urge you and your committee to move forward with making pseudoephedrine by prescription only. This product is the only ingredient that cannot be replaced by another in the illegal production of methamphetamine.

Here in Indiana we continue to be in the top 5 states, in the country, with the most number of illegal meth labs. Currently, we are on a pace to set another record for meth labs in 2012. The devastation this drug brings on our communities is way beyond the dollar figure used to combat this illegal drug and the costs to clean-up the aftermath of these toxic labs.

Mississippi and Oregon are proof that pseudoephedrine by prescription only works, and tracking does not.

The Indiana Drug Enforcement Association urges Congress to pass the legislation to stop this scourge on society.

Respectfully,

Gary W. Ashenfelter

Gary Ashenfelter, Training Director
Indiana Drug Enforcement Association

Great Lakes Regional Director
National Narcotic Officers' Association Coalition

MICHIGAN HIDTA
28 West Adams Suite 400
Detroit, MI 48226
313-967-4500 Office ~ 313-965-8770 Fax

July 27, 2012

The Honorable Trey Gowdy
Chairman, Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Gowdy,

As Executive Director of the Michigan High Intensity Drug Trafficking Area (HIDTA), I strongly support federal legislation that will require a prescription for products containing pseudoephedrine (PSE).

Methamphetamine production and use, and methamphetamine clandestine laboratories that require PSE for production, pose serious health and safety issues in Michigan. Intelligence reports from our law enforcement partners indicate that the number of methamphetamine laboratories in Michigan is increasing, and will continue to do so. The costs associated with providing treatment to methamphetamine users, and cleaning-up and disposing of hazardous material by-products of clandestine methamphetamine laboratories, places a tremendous financial strain on the health care and law enforcement communities.

Current efforts to control access to PSE through sale limits, log books and computerized monitoring systems have proven to be ineffective. Methamphetamine manufacturers continue to circumvent these control measures by creating organized *smurfing rings* which specialize in obtaining PSE from legal sources. Persons recruited into these rings often purchase PSE by presenting false identification and executing multiple small quantity purchases which remain below reporting requirement thresholds. The PSE is then either sold to methamphetamine manufacturers or traded for actual methamphetamine.

Oregon and Mississippi have achieved significant reductions in methamphetamine lab incidents since enacting legislation that requires a prescription for products containing PSE. I am confident that national legislation will have the same positive results throughout the United States.

Please feel free to contact me if I may be of assistance in this matter.

Respectfully,

Abraham L. Azzam
Executive Director
Michigan HIDTA
313-967-4505

Midwest High Intensity Drug Trafficking Area
10220 Northwest Ambassador Drive, Suite 720
Kansas City, Missouri 64153
Phone (816) 746-4911 Fax (816) 746-9712

July 26th, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Mr. Chairman:

The High Intensity Drug Trafficking Area Program supports and facilitates coordination among federal, local, state and tribal law enforcement to combat the most pressing drug threat in the region. The Midwest HIDTA established in 1996, consists of enforcement task forces and initiatives in the states of Missouri, Kansas, Iowa, Nebraska, South Dakota, North Dakota, and Illinois. In many of the Midwest HIDTA regions that immediate threat is locally produced methamphetamine. Local production is often small laboratories set up by methamphetamine users who obtain pseudoephedrine (PSE), one of the necessary precursor ingredients, from over-the-counter cold medications. The threat and dangers posed by clandestine methamphetamine labs in the Midwest requires immediate and effective action.

While maintaining a focus on major investigations and interdiction, local law enforcement in the Midwest still face the challenges of having to deal with the significant public safety hazards involved with these small methamphetamine labs. These hazards include fires, explosions, hazardous waste disposal, child abuse, violence, and environmental contamination. The number of local clandestine labs was at all-time highs during 2004 throughout all of the Midwest HIDTA states. With the enactment of local precursor chemical legislation in the various States followed by the Federal Combat Methamphetamine Epidemic Act in 2005, a dramatic decrease of domestic production occurred *initially*. However, as time has evolved the trend of lab discovery and investigations is increasing in numbers in our region, *significantly*.

Midwestern law enforcement recognizes from evidence found at meth lab sites, investigations, and intelligence, that although restricted, cold and allergy medicine is being obtained through the technique known as "smurfing." This is the practice of purchasing the

legal allowable amount of products containing PSE at one retail outlet but following up with successive purchases at other stores that in total exceed the daily or monthly legal limit. This can be done by one individual or a group of individuals operating together in one city, multiple cities, multiple counties, or multiple states depending on the sophistication of smurfing in any particular region. Significant amounts of meth precursor can be obtained in this fashion.

Law enforcement in the Midwest has observed smurfing techniques increasing in its sophistication. This level of criminal activity is reaching epidemic proportions across the country. A number of States in the Midwest HIDTA region have or are implementing the use of electronic monitoring techniques to combat this activity. The tracking or monitoring of the cold and allergy sales containing PSE is insufficient to address the increasing amount of clandestine labs. The Midwest HIDTA official position on this matter is: We see *no evidence* from the data and case information reviewed that electronic tracking systems work anywhere to *negatively affect local production of methamphetamine.*

In recent years the states of Oregon and Mississippi and some cities and counties in Missouri, have enacted legislation and ordinances to further control cold and allergy medicine containing PSE. Their rescheduling of pseudoephedrine and prescription purchase requirement has had a profound impact on the number of labs encountered by law enforcement in those areas. The action taken by these political leaders have resulted in an immediate and continued reduction in methamphetamine labs. The labs that have been discovered since are likely the result of pseudoephedrine purchased in bordering states that have less stringent controls on its sales.

I believe that a national law modeled after Oregon legislation requiring a physician's prescription to purchase pseudoephedrine would greatly reduce the number of clandestine methamphetamine labs and their inherent dangers throughout the United States. I strongly support federal legislation modeled after the introduced Meth Lab Elimination Act of 2009 as it would result in a marked reduction in methamphetamine labs in communities throughout the nation.

Respectfully;

David Barton
Director

801 W. Michigan Street
Milwaukee WI 53233

Phone: (414) 220-4740
Fax: (414) 224-7548

July 26, 2012

The Honorable Trey Gowdy
U. S. House of Representatives
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

As director of the Milwaukee High Intensity Drug Trafficking Area (HIDTA), I am pleased to write this letter of support to voice my strong support for federal legislation to require a prescription for products containing pseudoephedrine (PSE). The Milwaukee HIDTA was designated in 1998 and has grown from a one-county area to seven counties which encompass' 46% of Wisconsin's population.

While some states did create their own legislation to limit access to the precursor chemicals for Methamphetamine, many states in the U.S. do not have the necessary legislation in place to deal with the Methamphetamine threat. Oregon and Mississippi have enacted legislation and ordinances to further control cold and allergy medicine containing PSE. The rescheduling of pseudoephedrine and prescription purchase requirement has had a profound impact on the number of labs encountered by law enforcement in those areas.

Because of the uneven access to products containing PSE among the states, criminals are crossing state lines to obtain their chemicals in less restrictive states and transporting the chemicals to states that have laws in place, thus thwarting the progress made. It has become apparent to law enforcement officials throughout the country that the most effective way to respond to this latest threat is to have federal legislation to require a prescription for products containing pseudoephedrine (PSE).

In recent years the states of Oregon and Mississippi have enacted legislation to further control cold and allergy medicine containing PSE. Their rescheduling of pseudoephedrine and prescription purchase requirement has had a profound impact on the number of labs encountered by law enforcement. The action taken by these political leaders has resulted in an immediate and continued reduction in methamphetamine labs. The labs that have been discovered since are

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Respectfully,

Edward M. Polachek
Director

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

July 16, 2012

Mr. Marshall Fisher, Director
Mississippi Bureau of Narcotics
6090 I-55 South Frontage Road
Byram, MS 39272

Dear Mr. Fisher:

Please use the statement below as the Mississippi Division of Medicaid's response to your inquiry regarding any costs associated with the pseudoephedrine prescription law.

"For a number of years previous to the implementation of the legislation, the Mississippi Division of Medicaid had required a prescription for all over-the-counter drugs, including those containing pseudoephedrine. Medicaid beneficiaries who were receiving pseudoephedrine as part of their pharmacy benefits experienced no change in the way they acquired the medication following implementation of the law. As a result, the Division of Medicaid has not seen any increase in physician or pharmacy utilization or charges as a result of the pseudoephedrine legislation."

If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

David J. Dzielak, Ph.D.
Executive Director

DJD:pp

Suite 1000, Walter Sillers Building, 550 High Street, Jackson, MS 39201 (601) 359-6050

MISSISSIPPI PROSECUTORS ASSOCIATION

W. DEWAYNE RICHARDSON, PRESIDENT
RICHARD E. SMITH, PRESIDENT ELECT
PATRICIA BURCHELL, VICE PRESIDENT

RONNIE L. HARPER, NDAA REPRESENTATIVE
ANGEL MYERS, SECRETARY TREASURER

July 28, 2012

The Honorable Trey Gowdy, Chairman
Subcommittee on Health Care, District of Columbia,
Census, and the National Archives
Committee on Oversight and Government Reform
United States House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Re: Proposed Legislation to Make Pseudoephedrine a Controlled Substance

Dear Chairman Gowdy:

I wanted to inform you that the Mississippi Prosecutors Association as well as the District Attorneys for the State of Mississippi support all efforts to obtain legislation to make pseudoephedrine a controlled substance across the nation. Specifically, our association has voted to support those efforts and have authorized me, as President of the Mississippi Prosecutors Association, to advise you that the association supports such efforts.

The fight against methamphetamine and its users and those that make it has been an ongoing battle for several years. We are all concerned with the impact that methamphetamine has on our society, both in Mississippi and across the United States of America.

If we can assist you further in these efforts, please do not hesitate to contact me.

Sincerely,

W. Dewayne Richardson
District Attorney, 4th District of MS

P. O. Box 220 - JACKSON, MISSISSIPPI 39205
TOLL FREE IN MISSISSIPPI 800-852-1281 or (601) 359-4205 - FACSIMILE (601) 359-4200

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Executive Director
Robert I. L. Morrison

Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence

Testimony Submitted by the National Association of State Alcohol and Drug Abuse Directors (NASADAD)

July 24, 2012

House Committee on Oversight and Reform
Subcommittee on Healthcare, District of Columbia, Census and the National Archives

Rep. Trey Gowdy, Chairman
Rep. Danny Davis, Ranking Member

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for holding this hearing focused on the resurgence of methamphetamine in the United States, specifically the growth of small meth labs. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has been working to address methamphetamine abuse since the late 1990s. Our members, State Substance Abuse Directors have the frontline responsibility of managing our nation's publicly funded substance abuse system. NASADAD's mission is to promote effective and efficient State substance abuse systems.

The Association's number one message when it comes to methamphetamine 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 the countless Americans living in recovery, serves as the lynchpin of our work.

According to a national database, Treatment Episodes Data Set (TEDS), which tracks admissions to treatment in facilities that are licensed or certified by the State Substance Abuse Agency to provide substance abuse treatment, admissions for methamphetamine fell between 2005 and 2009 from 11.6 percent to 8.9 percent, but rates have not fallen below that of 2001.

As we are looking at these drug trends it is important to note, drug use trends impact States and regions within States differently. Missouri was one of the hardest hit by methamphetamine use, particularly the use of clandestine methamphetamine manufacturing. In rural areas this continues to be an issue. The State leads the nation with the number of meth lab seizures. In 2011 there were 2,058 labs found.

1025 Connecticut Avenue NW, Suite 605 • Washington, DC 20036 • (202) 293-0090 • Fax: (202) 293-1250 • Email: dcoffice@nasadad.org

The State's most recent *Status Report on Missouri's Substance Abuse and Mental Health Problems,* shows admissions to treatment for methamphetamine increased 4 percent between 2009-2010. In South Carolina, one of the States hardest hit regions, Greenville County has seen a 16 percent increase in admission for methamphetamine between 2002-2011. Statewide, South Carolina has seen a 5.7 percent increase in the same timeframe.[1]

To address substance use issues like methamphetamine we know it is important to close down meth labs, but we also need to reduce the demand for substance use services, this includes stopping people from starting to use in the first place, providing treatment and helping people recover. We also know there are many people in need of treatment who either do not receive treatment or are not able to access treatment.

According to the most recent National Survey on Drug Use and Health (NSDUH), 22.1 million individuals were classified with substance dependence. In that same year, 20.5 million individuals needed but did not receive treatment. In Missouri, out of the 383,500 individuals that needed services in 2008-2009, the State Substance Abuse Agency was only able to serve 55,500 individuals. The State Substance Abuse Agency is also responsible for treating individuals on probation and parole; only 16,400 of the 37,500 individuals in need of treatment are able to receive it as a result of budget limitations and lack of capacity.

In California, NSDUH shows that 383,412 individuals needed but did not receive treatment services in 2009. On any given day, over 5,250 Californians were on a wait list for treatment services. That same year an estimated 909,902 Texans over age 12 needed substance abuse treatment but only 63,059 Texans received treatment. The number of people on a treatment waiting list on a typical day in Texas totals approximately 977 adults and 43 youth.

An important component of our substance abuse prevention, treatment and recovery infrastructure, and providing individuals necessary services is the Substance Abuse Prevention and Treatment Block Grant, also known as the SAPT Block Grant. The program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). On average, it supports 42 percent of States' substance abuse expenditure. By law, 20 percent of the SAPT Block Grant must be spent on primary prevention, on average this represents 64 percent of States' substance abuse prevention expenditure, and in six States it is 100 percent. We know the program is effective. In 2011, individuals receiving services from SAPT Block Grant funded programs demonstrated high abstinence rates at discharge from both illegal drug (74 percent) and alcohol (78 percent) use and 92 percent reported no involvement in the criminal justice system.

We are concerned about the impact of federal cuts; specifically the effect sequestration would have on the SAPT Block Grant and States ability to address drug and alcohol issues, including methamphetamine. If the SAPT Block Grant is cut by 8.4 percent, as estimated by the Center on Budget and Policy Priorities, or by 7.8 percent, as estimated by the Congressional Budget Office, the SAPT Block Grant would be reduced by $149.4 million and $138.7 million from the FY

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[1] SOURCE: This report was produced from the South Carolina Department of Alcohol and Other Drug Abuse Services, Substance Abuse Agencies Management Information System (SAAMIS)

2012 level, respectively. Sequestration may also result in 169,375 fewer admissions to substance abuse treatment.

We would like to close with the following recommendations:

First, coordinate and collaborate with Single State Authorities for substance abuse or SSAs. The job of each SSA is to plan, implement and evaluate a comprehensive system of care. 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 number one priority for NASADAD is the SAPT Block Grant – the foundation of our treatment system.

Thank you again for the Subcommittee's attention to this important issue and the opportunity to provide input.

Sincerely,

Robert I.L. Morrison
Executive Director

NATIONAL **HIDTA** ASSISTANCE CENTER
11200 NW 20th St., Suite 100 Miami, FL 33172
Phone (305) 715-7600
Fax (305) 715-7615
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July 27, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee of Health Care, District of Columbia, Census, and the National Archives
Committee of Oversight and Government Reform
U. S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

As the Director of the National HIDTA Assistance Center (NHAC), I am writing this letter of support for federal legislation requiring prescription for obtaining products containing Pseudoephedrine (PSE).

The National HIDTA Assistance Center (NHAC) was created in 1996 to assist in the development of all HIDTAs. The success and continuous expansion of the HIDTA Program, combined with the fact that individual HIDTAs operate with not only diverse threats, but in a largely decentralized fashion, at different levels of maturity and with different funding levels, has created the need for assistance in promoting cooperation, communication and appropriate standardization among the HIDTAs.

The NHAC does not maintain a direct law enforcement function but supports disrupting the market by improving the capabilities of the HIDTA supervisors and assisting with the electronic connectivity and fiscal accountability of all thirty-two HIDTA offices.

The NHAC proudly supports the federal legislation to require prescriptions to obtain pseudoephedrine in an effort to stop the propagation of Meth labs around the country, which in turn will help curtail the epidemic that is plaguing our communities.

Respectfully,

William I. Martin
Director

Written Statement of
Holly E. Dye
Founder and Executive Director
National Drug Endangered Children Training and Advocacy Center, Inc.

Before the

United States House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Health Care, District of Columbia, Census and the National Archives

Hearing: Meth Revisited: Review of State and Federal Efforts to Solve the Domestic Methamphetamine Production Resurgence

July 24, 2012

Dear Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee:

Thank you for giving me the opportunity to present my perspective on the impact of pseudoephedrine as it relates to criminal activity, methamphetamine production, and specifically, endangerment and exploitation of children.

Methamphetamine: Two Decades of Child Victimization

The past twenty years have been frustrating for those attempting to protect children from the harms of dangerous drug environments. These individuals include those in law enforcement, social services, mental health providers, and educators. For those of us working with children living in environments where drugs are used, distributed, and manufactured, there are a number of high-level risks posing danger to health and well-being. These include chemical exposure, access to dirty drug needles, environmental exposure to drug smoke (which results in children testing positive for these drugs), sexual abuse including use of a child as the currency with which drug debts are eliminated or drugs are purchased, and use of a child in the commission of a crime. Methamphetamine is a drug that poses each of these risks to children.

Unfortunately, although states such as Mississippi and Oregon have successfully instituted legislation to prohibit sales of pseudoephedrine without a prescription, other states have opted to further reduce quantities that may be purchased within a 30-day period or to simply institute a tracking system. As with other criminal issues, those seeking to acquire pseudoephedrine have quickly organized to by-pass these restrictions. Smurfing groups have organized and armed with false identification cards target pharmacy-rich communities. Members of these organized groups target children and the elderly in attempt to make them appear less suspicious while attempting to make excessive purchases of pseudoephedrine. Children are forced to go from store to store,

sometimes crossing multiple county and state lines within a day's time. The street value of pseudoephedrine has risen to $80 per box in some areas.

Pharmacists have expressed fear of personal safety as being the person tasked with telling one of these individuals their purchase will not be approved. Methamphetamine and the acquisition of necessary precursors have created a high-risk environment for many professionals who are simply doing their job.

Specific Risks to Children

Among the greatest concerns specific to methamphetamine use include risk of death due to parental disregard for children's needs.

- It was July 21, 1995 when Genevieve "Genny" Rojas was placed with relatives in Chula Vista, California while her mother was in rehab and her father in prison for drugs. She was beaten, tortured, and bound for six months before being scalded to death by her aunt and uncle who were methamphetamine users. Ivan and Veronica Gonzales are spending life on death row for her death.

- On December 26, 1995, three children, ages 3, 2, and 1 year belonging to Kathy Lynn James died in Riverside, California due to a meth-manufacturing related fire. James' 7 year old son was able to escape through a window after following his mother. The deaths of these children led to national attention regarding the impact of methamphetamine specifically to children. Kathey Lynn James, the children's mother is currently serving 45-years to life for the deaths of her children for escaping the fire and leaving them behind.

- On January 25, 2005 in Crothersville, Indiana, Katie Collman, age 10 years, was sent to buy a loaf of bread for family but encountered along her path Anthony Stokleman who was manufacturing methamphetamine in southern Indiana. Becoming paranoid she had seen him, he kidnapped, raped and murdered her.

- On December 14, 2004, Kaylynn Gaddie, 18-months old, was found after a five day search. She died of blunt force trauma to the head, placed in a trash bag and tossed over a guardrail into a ravine in Louisville, KY, by her mother's boyfriend, Shawn Michael Shaw. Shaw had missed a sentencing date for previous crimes three months before her death in December 2004. Kaylynn's own mother did not report her child as missing because of her own outstanding warrant.

- May 2009, Kayden Branham, 20-months-old died in Monticello, Kentucky after drinking drain cleaner left on a table during a methamphetamine cooking lesson. His fourteen-year-old mother was living with a relative under court supervision and was present along with Kayden's nineteen-year-old father and additional adults who were involved in methamphetamine production. She was injected with methamphetamine by an uncle

> because she "couldn't" do it herself and reported to police that the pills her father gave her after Kayden's death were not working to calm her.

Additional risks to children's health and well-being include needle sticks, rampant sexual abuse, exposure to extreme violence and live sex acts, and use of a child as a currency to obtain drugs, or a decoy to detract attention from illegal drug activity. The latter tactic is commonly used in border trafficking of drugs and is becoming increasingly common even in small communities. Each risk is commonly found in methamphetamine using, distributing, and manufacturing environments but are documented and investigated at declining rates according to EPIC (El Paso Intelligence Center) statistics. Reasons offered locally for this includes limited resources to investigate every small lab or smurfing report, especially since law enforcement budgets have been cut. Additionally, methamphetamine related investigations have been downgraded by some social service agencies who mistakenly believe the transition to one-pot methamphetamine manufacturing methods equate to lessened risk to the children who may be affected.

Cost of Methamphetamine

Investigation of pseudoephedrine smurfing rings are time consuming and difficult due to the abundant use of false identification by those making purchases. Investigations of manufacturing environments require the use of costly protective gear, require additional specialized training, and result in substantial additional cost to local and state agencies responsible for proper disposal of hazardous chemical waste. Child welfare agencies are faced with protecting children who most certainly will remain in state's custody much longer than the Adoption Safe Families Act (ASFA) requirement of permanency planning to be accomplished within fifteen months of removal from a parent's custody. ASFA guidelines also mandate that a child be returned to parent custody as the first permanency option.

The cost of caring for a child in the foster care system can cost $184 per day of care, or in excess of $83,000 per year for one child. This cost can increase and even double if hospitalization of a child is required. Babies born with methamphetamine in their system join the ranks of other prenatally exposed newborns commonly referred to as "million dollar babies", referencing the cost of healthcare during the first month of life. For children living with drug using and distributing caregivers, exposure to extreme violence and sexual exploitation commonly results in childhood trauma at an annual estimated cost of $94 billion dollars, according to federal estimates. Substance abuse treatment facilities provide services to adults of whom two-thirds report being abused as children.

In my experience working with addicts and their children, it is the children taking on the role of adult and the adult focusing completely on that which supports drug acquisition. Although there is no dispute many of these individuals may seek to acquire pseudoephedrine for the sole purpose of personal use, it is an incorrect to presume this activity creates no victims within

communities or family. The social cost to children who are unable to perform educationally, who acquire non-organic psychiatric problems secondary to trauma experienced in a drug-fueled environment, who have never known a prenatal or postnatal day of life free from drugs in their system, and who lose hope in a system they are taught will protect them if only they tell an adult is extensive. The cost of care must be absorbed by communities and state governments.

Summary

Just as a child whose parent is in prison is more likely to go to prison, such is a child of an addict an estimated three to seven times more likely to become an addict themselves and more likely to quit school before graduation. It is time to act in a way that will clearly remove one drug option with a proven history of death, destruction, and horrific abuse of children; restricting availability of pseudoephedrine, the mandatory precursor for the manufacture of methamphetamine.

I thank the Subcommittee for giving me this opportunity and thank you for your work on this issue.

Nevada High Intensity Drug Trafficking Area
550 South Main Street, Las Vegas, Nevada 89101
(702) 759-8070 FAX: (702) 759-8035 Email: NVHIDTA@lvmpd.com

NV HIDTA Director
L. Kent Bitsko

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CCDA
DA Steve Wolfson

DEA
Acting SAC Briane Grey

ASAC Paul Rozario

FBI
SAC Kevin Favreau

HPD
Chief Patrick Moers

ICE/HSI
SAC Claude Arnold
ASAC Michael A. Harris

IRS
SAC Paul Camacho

LVMPD
Sheriff Doug Gillespie

NV DPS
Director Chris Perry

NVNG
Lt. Col. Brian Thayer

NLVPD
Chief Joseph Chronister

RPD
Chief Steve Pitts

SPD
Chief Steve Keefer

USAO
USA Dan Bogden

USMS
USM Christopher Hoye

WCDA
DA Richard Gammick

WCSO
Sheriff Mike Haley

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia,
Census, and the National Archives
Committee on Oversight and Government Reform
U. S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy,

Nevada has been dealing with a meth epidemic for the last 20 years with the meth usage continuously on the rise. In past years, we have had a serious problem with methamphetamine labs that took up a considerable amount of time, effort, and money for local agencies. Meth has also posed a significant health and welfare threat to the citizens of Nevada.

During the last few years our meth labs have diminished somewhat, but the demand for methamphetamine has not waned at all. A bill making pseudoephedrine prescription-only would ensure that we would not have a return to the days of having a meth lab every day in the state of Nevada.

Sincerely,

L. Kent Bitsko, Director

LKB:cs

New England
High Intensity
Drug Trafficking Area
Methuen, MA 01844-1947

July 26, 2012

The Honorable Trey Gowdy
U.S. House of Representatives
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Gowdy:

As Director of the New England High Intensity Drug Trafficking Area (HIDTA) for the New England region, I am pleased to write this letter of support for federal legislation to require a prescription for products containing pseudoephedrine (PSE).

Statistics indicate clandestine methamphetamine laboratories continue to increase across most of our country. The exception to this trend is in the states of Oregon and Mississippi, which require prescriptions for PSE products. PSE is the key precursor for the most commonly produced methamphetamine.

Unfortunately, most efforts to control access to PSE through requirements contained in the 2006 Combat Methamphetamine Epidemic Act (CMEA) have proven ineffective. Methamphetamine manufacturers are able to circumvent existing restrictions through the use of false identifications, organized "smurfing" rings and retail employee collusion. Even the most advanced enforcement through electronic tracking of PSE sales has proven ineffective.

Responding to methamphetamine laboratory clean-ups and investigations is also placing a tremendous strain on law enforcement agencies. Not only does the use of methamphetamine drive a tremendous number of thefts and other crimes, but the clean-up of these laboratories has become an expensive burden on law enforcement agencies. These negative effects could be reduced by passing federal legislation to require prescriptions for PSE-based products.

Thank you for your leadership on the subcommittee that is considering federal legislation on this issue. Should you have any questions or need additional information or assistance, please do not hesitate to contact me.

Respectfully,

J.T. Fallon
Executive Director
New England HIDTA

OREGON HIDTA PROGRAM

HIGH INTENSITY DRUG TRAFFICKING AREA

Representative Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

July 26, 2012

Mr. Chairman:

The Oregon High Intensity Drug Trafficking Area (HIDTA) Program supports and facilitates coordination among federal, local, state and tribal law enforcement in Oregon to combat the most pressing drug trafficking threat in the region. Until 2006, the most pressing drug threat was methamphetamine that was manufactured in small laboratories by methamphetamine users who freely and uninhibitedly obtained pseudoephedrine, the most necessary precursor ingredient, from over-the-counter cold medications.

The harmful impacts of methamphetamine are not limited only to the effects the drug has on users, but also include the dangerous effects of the chemicals and wastes involved in producing methamphetamine. These labs are highly toxic and extremely dangerous to everyone who comes into contact with them and the locations where waste products have been dumped.

In recognition of the significant public health and safety threat posed by pseudoephedrine based methamphetamine labs, the Oregon Legislature passed laws in 2005 which restricted the availability of pseudoephedrine and that ultimately requires a prescription from a physician in order to purchase it. The legislature's action resulted in an immediate, significant and sustained decrease in methamphetamine labs seized by law enforcement agencies in Oregon. Between 2004 and 2005 methamphetamine labs seized declined 57% from 448 to 192. In 2011 law enforcement agencies in Oregon seized 10 methamphetamine laboratories, an all-time low and which is a 98% decrease from the 448 seized in 2004.

The methamphetamine labs that have been discovered in Oregon since the prescription only law was passed are likely the result of pseudoephedrine purchased in bordering states that have less stringent controls on its sale. I believe that a national law modeled

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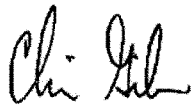
Telephone: (503) 378-5123 Fax: (503) 373-3196

after Oregon's legislation requiring a prescription from a physician to purchase pseudoephedrine would not only further reduce the number of methamphetamine labs in Oregon; it would also reduce the number of clandestine methamphetamine labs and their inherent dangers in communities throughout the rest of the United States.

Respectfully,



CHRIS GIBSON, Director
Oregon High Intensity Drug Trafficking Area

610 Hawthorne Avenue, SE, Suite 120, Salem, Oregon 97301
Telephone: (503) 378-5123 Fax: (503) 373-3196

SUZANNE McCLAIN ATWOOD
Executive Coordinator

TRENT H. BAGGETT
Assistant Executive Coordinator

STATE OF OKLAHOMA

DISTRICT ATTORNEYS COUNCIL

421 N.W. 13TH STREET, SUITE 290 • OKLAHOMA CITY, OKLAHOMA 73103

EXECUTIVE	FISCAL	GRANTS	VICTIMS	MIS
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FAX 405-264-5099	405-264-5099	405-264-5095	405-264-5097	405-264-5099

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman,

As Drug Task Force Coordinator for the State of Oklahoma, I am in continual contact with the 19 drug task forces located throughout the state. As I meet with them I ask them what problems they are encountering in the field, and what trends are occurring in their investigations. Our State initiated a pseudoephedrine (PSE) tracking program several years ago, and that helped, but methamphetamine cooks have found a way around it by manufacturing meth in very small quantities. Now, someone can still legally purchase a box of PSE and make their meth with very little problem. Also, the tracking system does not stop those who choose to purchase their legal limit of PSE and sell it to a meth cook in a process referred to as "smurfing." Without a doubt, Oklahoma is besieged by "shake and bake" meth labs, which are fueled by PSE purchased by individuals who travel from store to store to obtain this requisite precursor to meth production.

In this past legislative session, a bill was introduced in our state which would make PSE a "prescription only" drug, however it failed to pass. The drug task forces of the State of Oklahoma need your help to regulate PSE. Since Arkansas passed a law regulating PSE by making the pharmacist the gatekeeper, and several municipalities in Missouri are requiring a prescription, the traffic at our pharmacies in Eastern Oklahoma has increased tremendously. People are flocking from Arkansas and Missouri to Oklahoma in order to obtain their PSE to manufacture meth.

We urge the passage of a bill that mandates that pseudoephedrine products be regulated and be made available by prescription only.

Thank you,
Karen L. Hess
Drug Task Force Coordinator

OHIO HIGH INTENSITY DRUG TRAFFICKING AREA
984 Keynote Circle
Brooklyn Heights, OH 44131-1828
Phone 216-739-3500 Fax 216-739-3518

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Mr. Chairman:

The High Intensity Drug Trafficking Area Program supports and facilitates coordination among federal, local, state and tribal law enforcement to combat the most pressing drug threat in the region. The Ohio HIDTA established in 1999, consists of enforcement task forces and initiatives throughout the State of Ohio. Much of the methamphetamine threat is locally produced by using small laboratories set up by methamphetamine users who obtain pseudoephedrine (PSE), one of the necessary precursor ingredients, from over-the-counter cold medications

While maintaining a focus on major investigations and interdiction, local law enforcement in the Midwest still face the challenges of having to deal with the significant public safety hazards involved with these small methamphetamine labs. The cost of cleanup and the various health hazards are making methamphetamine a growing problem. Law enforcement agencies that come across these small labs do not have funding to clean up the environmental hazard that is created. I believe the best way to stop this growing problem is to stop the PSE from being readily available.

In recent years the states of Oregon and Mississippi and some cities and counties in Missouri, have enacted legislation and ordinances to further control cold and allergy medicine containing PSE. Their rescheduling of pseudoephedrine and prescription purchase requirement has had a profound impact on the number of labs encountered by law enforcement in those areas.
I believe that a national law modeled after Oregon legislation requiring a physician's prescription to purchase pseudoephedrine would greatly reduce the number of clandestine methamphetamine labs and their inherent dangers throughout the United States. I strongly support federal legislation modeled after the introduced Meth Lab Elimination Act of 2009 as it would result in a marked reduction in methamphetamine labs in communities throughout the nation.

Sincerely

Derek Siegle
Executive Director
Ohio HIDTA

North Florida High Intensity Drug Trafficking Area

Edward Williams
Director

8647 Baypine Road, Suite 300, Jacksonville, Florida 32256
Telephone: 904-256-5999 - Fax: 904-256-5904
E-Mail: ewilliams@nfhidta.org

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Doug Stoutsma

USCG - Captain
Andy Blamme

USMS - US Marshal
Bill Berger

July 30, 2012

The Honorable Trey Gowdy, Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Mr. Chairman:

As the director of the North Florida High Intensity Drug Trafficking Area (NFHIDTA), I am writing to thank you and your committee for your important focus on the scourge of methamphetamine and your consideration of legislation requiring a physician's prescription for the purchase of pseudoephedrine.

The NFHIDTA covers 10 counties in northeast Florida and this year we are seeing unprecedented levels of lab seizures. Many of these involve small levels of production through what is commonly called "the one pot method". The tracking system in the state is not proving an effective deterrent to the groups of purchasers called "smurfs." They travel across State lines, and use numerous altered and fictitious identification documents to avoid apprehension. We are becoming increasingly aware that what may appear as a legitimate purchase in a tracking system is in fact recorded to a false or altered name. We are also aware of the limitations where a system in one State has no communication with its neighboring States.

Methamphetamine is universally recognized as one of the most destructive drugs for its users. Its manufacture poses immediate health, safety, and environmental concerns. Costs for cleaning up after production are running at tens of millions of dollars annually. Now, we are also facing the cumulative effect on our communities of small, easily thrown aside, one pot labs.

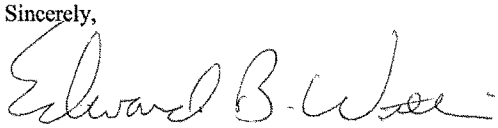
At the same time, we see the effectiveness of laws in Oregon and Mississippi and in individual cities and counties in Missouri that require a physician's prescription for the purchase of the essential raw material found in these labs, pseudoephedrine.

The Honorable Trey Gowdy, Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives

It seems that the choices on this are very clear. We can chase the distribution of pseudoephedrine for illicit purposes, inefficiently and at a high cost, or we can stop it, while still maintaining availability to patients who require it.

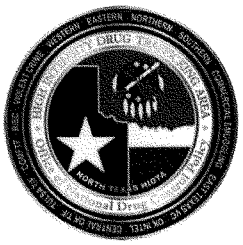
We appreciate your leadership and the Committee's willingness to look at this issue with the clear focus you did in recent direct testimony.

Sincerely,



Edward B. Williams
Director NFHIDTA

July 25, 2012



The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of
Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building

Dear Mr. Chairman,

I am writing to request a copy of the hearing record supporting a prescription-only policy for PSE products. As the Director of the North Texas HIDTA that covers six counties in Oklahoma and 15 counties in the north Texas region I am keenly aware of the positive impact this legislation would have on our area. I would like to share the document with my Executive Board and staff that work daily to reduce the negative impact drug abuse, drug trafficking and drug production has on our community.

Two of our areas, Tulsa and Oklahoma City, Oklahoma, are significantly impacted by methamphetamine production. Illegally obtained pseudoephedrine has been utilized to produce methamphetamine throughout our region. Meth production is an extremely dangerous undertaking. It puts "meth cook" and all those in close proximity of these chemicals at high-risk. Of greatest concern is the exposer of these toxic chemicals to unsuspecting children, innocent neighbors and the law enforcement community. The U.S. Government spends millions of dollars on hazardous material clean ups from these labs. I believe this legislation would significant positive impact on the counterdrug efforts.

Lance Sumpter
Director
North Texas HIDTA
(972) 915-9501

NEW JERSEY NARCOTIC ENFORCEMENT OFFICERS ASSOCIATION

A Message From The NJNEOA

July 26, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

The New Jersey Narcotic Enforcement Officers Association is an organization comprised of law enforcement officers in the State of New Jersey who are tasked with enforcing the state's drug statutes.

One of the most dangerous and rampantly used drugs in the United States today is the central nervous system stimulant Methamphetamine. A highly addictive drug, which causes both chemical and molecular changes in the brain. Use of the drug causes such physical reactions as: mood disturbances, violent behaviour, psychosis, paranoia, visual and auditory hallucinations, and delusions.

Classified as a Schedule II drug, Methamphetamine, whose medical uses are limited, is available only through a prescription, is not refillable, and the doses prescribed are much lower than those typically abused. It is however, available both domestically and abroad where it is being made in illegal laboratories. That method of manufacturing poses a danger to both the environment and those unwitting individuals living near such illegal drug labs.

Pseudoephedrine is a safe, effective and widely used over the counter decongestant commonly utilized in the illegal manufacturing of Methamphetamine. Even with the federal restrictions placed upon the sale of Pseudoephedrine in 2006, the legitimate precursor chemical, remains to be highly sought after by those involved in illegal Methamphetamine manufacturing.

It is for those reasons stated above, that the New Jersey Narcotic Enforcement Officers Association (NJNEOA) supports a prescription-only policy for products containing Pseudoephedrine.

If there is any doubt on the stance that the NJNEOA has regarding this matter, please contact us at editor@njneoa.org or 732-925-1998 so that we may discuss this issue.

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Contact email: editor@njneoa.org

You are receiving this message on behalf of the http://njneoa.org/

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

As law enforcement professionals, we write to express our strong support for federal legislation to require a prescription for products containing pseudoephedrine (PSE).

As you know, the number of meth labs is increasing across most of our country, creating a problem for law enforcement agencies. The exception to this trend is in the states of Oregon and Mississippi, which require prescriptions for PSE products. PSE is the key precursor ingredient for the most common method of cooking meth. Unfortunately, earlier efforts to control access to PSE through log-books and sales limit restrictions, contained in the Combat Methamphetamine Epidemic Act (CMEA), as enacted by Congress in 2006, have now proven ineffective.

Meth manufacturers, both small scale cooks and large "super lab" operations, are now circumventing CMEA restrictions through the use of false IDs, organized "smurfing" rings, and retail employee collusion. Even the most advanced enforcement of the CMEA, through electronic tracking of PSE sales, is now ineffective.

The inadequacies of the CMEA also allow smurfers and meth cooks to circumvent the otherwise effective prescription-only laws in Oregon and Mississippi by simply crossing state lines to purchase PSE. Officers in both states have found direct evidence that PSE is being brought into their states. As law enforcement professionals, we believe that even the most effective state laws cannot prevent meth from being trafficked across state lines. This is why a law at the federal level is vital to successfully controlling meth.

Last Year NC enacted a bill to implement the NPLEx tracking/blocking system in North Carolina, HB12, Ban Methamphetamine Labs. In 2011 the NC SBI reported 344 clandestine laboratory responses, an all-time high. As of June 30, 2012, NC SBI reports 253 clandestine lab responses. At this pace the number of lab responses in 2012 will double over 2011, in spite of the implementation of the so-called blocking system.

In Kentucky, a state with one of the most advanced e-tracking systems, meth labs have skyrocketed from 298 in 2007 to 1515 in 2011. By comparison, meth labs in Oregon have decreased by over 96%, and in Mississippi, the number of labs went down by 68% in the first six months after enactment of their PSE prescription-only law.

Finally, this explosion of meth labs is placing a tremendous strain on law enforcement agencies. Not only does the use of meth drive a tremendous number of thefts and other

crimes, but the clean-up of meth labs places an expensive burden on law enforcement agencies because of the hazardous materials involved.

These negative effects could be reduced by passing a federal law to require a prescription for PSE. Until 1976, PSE was a prescription product. It is time to return to that sensible approach for regulating the sale of PSE, and replicating Mississippi and Oregon's success in eliminating meth labs.

Thank you for your leadership in pushing to enact a federal law to require a prescription for PSE products and help eliminate meth labs. We, the law enforcement officers listed below, stand ready to assist you in any way possible to enact this vital policy.

Sincerely,
Phillip Little
Training Director
NC Narcotic Enforcement Officers Asso.

PHILADELPHIA / CAMDEN
HIGH
INTENSITY
DRUG
TRAFFICKING
AREA

July 27, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

As Director of the Philadelphia-Camden High Intensity Drug Trafficking Area (PC HIDTA) program, I would like to thank you and your committee for its attention to the problem of domestic methamphetamine production. I am pleased to add my support to the efforts currently underway in committee that would establish a national requirement for products containing pseudoephedrine (PSE), a methamphetamine precursor chemical, to be sold "by prescription only." This measure would greatly aid law enforcement efforts to control the production and proliferation of methamphetamine in our communities.

Established in 1995, the PC HIDTA provides assistance to law enforcement agencies to combat the trafficking of drugs in four counties in the greater Philadelphia region. Our HIDTA is located at the intersection of four states: Pennsylvania, New Jersey, Delaware and Maryland. These states are situated within the densely populated and heavily travelled I-95 corridor. While our experience to date has shown that most of the methamphetamine consumed in the region is produced in the Southwestern U.S. and in Mexico and brought into the region by trafficking groups, increasingly meth users are acquiring PSE to make the drug themselves in small batches, or are assisting local producers of meth by acquiring PSE in exchange for the drug, in what are commonly known as "one-pot" method labs.

Federal controls established by the "Combat Methamphetamine Epidemic Act of 2005" have succeeded in restricting how PSE is marketed in retail establishments, including requiring stores to keep such products behind the counter, limiting the amount of PSE products one can purchase each month, and requiring buyers show identification at the time of purchase. All of these have helped to some degree control the amount of PSE available to the public. However, many illegitimate purchasers use false IDs, and reporting practices and information sharing mechanisms vary from state to state, proving such measures to be ineffective in curbing the practice of "smurfing" – illegitimately purchasing and pooling PSE for the purposes of manufacturing meth – by individuals or groups of persons working in concert with a meth "cook". In a region such as ours, it is far too easy to skip back and forth across state lines to make multiple purchases of PSE that elude the notice of law enforcement and regulatory authorities. As a result, "smurfing" is responsible for generating the vast majority of supplies of precursor chemicals to meth producers.

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Suite A
Philadelphia, PA 19153

Main: 215-863-3480
Fax: 215-863-3495

www.pchidta.org

To illustrate the growing problem to local communities posed by small meth labs that use over-the-counter PSE products to manufacture meth, Pennsylvania law enforcement reported seizing only 15 clandestine meth labs, making 8 chemical seizures and discovering just one dumpsite for a meth lab in 2007, the first full year the Combat Meth Act was in effect. By contrast, in 2011, Pennsylvania reported seizing 60 labs, making 14 chemical seizures and discovering 14 dumpsites. Year-to-date data indicates Pennsylvania is on pace to significantly exceed the 2011 figures. This dramatic increase within five years is directly attributable to the continued availability of PSE products as currently regulated.

Measures taken in Oregon and Mississippi, requiring a doctor's prescription for the purchase of PSE, have shown to be most effective in controlling the illegitimate purchase of PSE-based products. But efforts to enact similar legislation in other states have been unsuccessful. Clearly, the most effective means of limiting the illegitimate availability of PSE is by establishing a national standard that requires a physician's prescription for dispensing products containing it.

It is my sincere hope that the committee will stand with law enforcement and put forth legislation that will have an immediate and lasting impact on public health and safety by limiting PSE sales to "by prescription only." Many thanks in advance for your consideration of this important issue.

Sincerely,

Jeremiah A. Daley
Executive Director

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

HIGH INTENSITY DRUG TRAFFICKING AREA
PUERTO RICO – US VIRGIN ISLANDS

July 26, 2012

(Sent via email to john.zadrozny@mail.house.gov)

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chair Gowdy:

RE: House Oversight Committee's Subcommittee on Health Care Hearing

We write for the hearing record in support of a prescription-only policy for products containing pseudoephedrine. We are of the opinion that requiring prescriptions would be in our Nation's best interest and contribute to the reduction of the availability of illegal drugs.

Please do not hesitate to contact us if you have any questions.

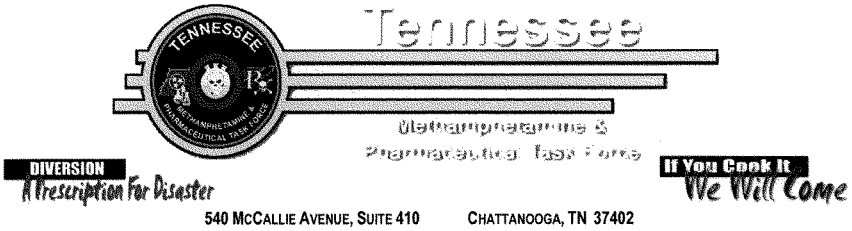
Sincerely,

Jacinto L. Mills
for
Jose M. Alvarez
Director,
Puerto Rico/U. S. Virgin Islands,
High Intensity Drug Trafficking Area (HIDTA)

cc: PR/USVI HIDTA Executive Board

Tel: 340.693.2228 • Fax: 340.777.5426 • E-Mail: cmills@prvi.hidta.net
P. O. Box 309480, St. Thomas, VI 00803-9480

"COMMITTED TO EXCELLENCE"



540 McCallie Avenue, Suite 410 Chattanooga, TN 37402
Phone - (423)752-1479 FAX - (423)267-8983 www.rid-meth.org

July 27, 2012

Honorable Trey Gowdy
Chairman, Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515
(Forwarded via email to john.zadrozny@mail.house.gov)

RE: Methamphetamine and Pseudophedrine – A Prescription-Only Policy Solution

Dear Mr. Chairman:

The Tennessee Methamphetamine and Pharmaceutical Task Force (TMPTF) and its member law enforcement agencies strongly and fervently support the return of a National prescription-only policy for products containing pseudophedrine (PSE).

The TMPTF has been actively fighting the scourge of the illegal manufacture of meth and the distribution of the resultant end product in Tennessee since 1999. Tennessee has numbered in the top five states in the Nation over the past several years in the number of seizures of clandestine meth laboratories, which has created a tremendous financial and societal burden to law enforcement, our citizens, and victimized drug endangered children. The distribution of illegally manufactured meth in Tennessee is at an all-time high even with the constant battle that the TMPTF and local, state, and federal law enforcement agencies, along with the Legislature and the Office of the Governor, have waged.

The *Meth-Free Tennessee Act of 2005* was a huge step which resulted in PSE being sold only at pharmacies and only from behind the counter with identification and signature being provided to purchase. The *Act* also provided a monthly cap on the number of grams of PSE which could be purchased by an individual. The recent *I Hate Meth Act* provided additional assistance in tracking sales. However, even with these legislative efforts, 2012 PSE sales have increased by16% over sales in 2011. Historically, seizures of clan meth labs in Tennessee parallel PSE sales and thus far in 2012, seizures have increased by 20% over last year.

A study is currently being conducted by the Tennessee Office of Comptroller with the ultimate objective of curtailing the manufacture and use of methamphetamine in Tennessee through reduction of access to PSE products. One goal of the study is to evaluate whether PSE products should become available by prescription only.

The battle against meth in Tennessee still rages. After years of working with law enforcement, state government officials, and the Legislature on this problem, the TMPTF contends that a prescription-only policy would provide relief and reduction in illegal clan meth labs in Tennessee as no other past legislation has provided. Therefore, the TMPTF supports a prescription-only policy and wholeheartedly supports the efforts of those in Congress who are examining this alternative.

Please feel free to contact me at (423)752-1479 or thomas.farmer@tn.gov if you have any questions or if the TMPTF can be of assistance in this matter. Again, the TMPTF completely supports these endeavors on a prescription-only policy as a solution to the ongoing methamphetamine epidemic in Tennessee and across the Nation.

Sincerely yours,

Thomas N. Farmer
Director

SOUTHWEST BORDER – SOUTH TEXAS HIDTA
8600 WURZBACH ROAD, SUITE 802
SAN ANTONIO, TEXAS 78240
(210) 692-1532 – TELEPHONE
(210) 692-1891 – FACSIMILE

July 27, 2012

The Honorable Trey Gowdy
U.S. House of Representatives
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Gowdy:

As director of the Southwest Border High Intensity Drug Trafficking Area (HIDTA) for the South Texas Region, I am pleased to write this letter to express my strong support for federal legislation to require a prescription for products containing pseudoephedrine (PSE).

Statistics indicate clandestine methamphetamine laboratories continue to increase across most of our country. The exception to this trend is in the states of Oregon and Mississippi, which require prescriptions for PSE products. PSE is a key precursor for methamphetamine. Additionally, evidence indicates that most current state laws cannot prevent methamphetamine from being illicitly produced and trafficked across state lines.

Most efforts to control access to PSE through log-books and sale limits, which are requirements contained in the 2006 Combat Methamphetamine Epidemic Act (CMEA), have proven ineffective. Illicit methamphetamine lab operators are able to circumvent existing restrictions through the use of false identifications, organized "smurfing" rings and retail employee collusion. Even the most advanced enforcement through electronic tracking of PSE sales has proven ineffective.

The use of methamphetamine causes a tremendous number of thefts and violent crimes. The clean-up of these laboratories has become an expensive burden on law enforcement agencies. The negative effects could be reduced by passing federal legislation to require prescriptions for PSE-based products.

Thank you for your leadership on the Subcommittee considering federal legislation on this issue. It is time to enact a law that will regulate the sale of PSE-based products and replicate the successes that Oregon and Mississippi have experienced with their state legislation. Should you have any questions or need additional information or assistance, please do not hesitate to contact me at the above listed telephone number.

Respectfully,

Tony Garcia, Regional Director
Southwest Border HIDTA-South Texas Region

Southwest Border HIDTA - New Mexico
High Intensity Drug Trafficking Areas Program
2450 Lakeside Dr. Bldg. A, Las Cruces, NM 88007
PH (575) 541-7501 Fax (575) 541-7510

July 26, 2012

The Honorable Trey Gowdy
U.S. House of Representatives
Chairman
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Gowdy:

As director of the Southwest Border High Intensity Drug Trafficking Area (HIDTA) for the New Mexico Region, I am pleased to write this letter of support to express my strong support for federal legislation to require a prescription for products containing pseudoephedrine (PSE).

Statistics indicate clandestine methamphetamine laboratories continue to increase across most of our country. The exception to this trend is in the states of Oregon and Mississippi, which require prescriptions for PSE products. PSE is the key precursor for the most commonly produced methamphetamine. Additionally, evidence indicates that most current state laws cannot prevent methamphetamine from being manufactured and trafficked across state lines.

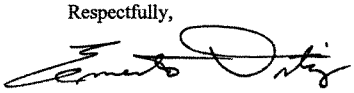
Unfortunately, most efforts to control access to PSE through log-books and sale limits, which are requirements contained in the 2006 Combat Methamphetamine Epidemic Act (CMEA), have proven ineffective. Methamphetamine manufacturers are able to circumvent existing restrictions through the use of false identifications, organized "smurfing" rings and retail employee collusion. Even the most advanced enforcement through electronic tracking of PSE sales has proven ineffective.

Responding to methamphetamine laboratory clean-ups and investigations is also placing a tremendous strain on law enforcement agencies. Not only does the use of methamphetamine drive a tremendous number of thefts and other crimes, but the clean-up of these laboratories has become an expensive burden on law enforcement agencies. These negative effects could be reduced by passing federal legislation to require prescriptions for PSE-based products.

Thank you for your leadership on the Subcommittee that is considering federal legislation on this issue. It is time to enact a law that will regulate the sale of PSE-based products and replicate the

successes that Oregon and Mississippi have experienced with their state legislation. Should you have any questions or need additional information or assistance, please do not hesitate to contact me at the above listed telephone number.

Respectfully,



Ernesto Ortiz, Regional Director
Southwest Border HIDTA-New Mexico Region

South Carolina Crime Victims' Council
1900 Broad River Road
Columbia
South Carolina 29210
WWW.SCCVC.ORG

Board of Directors:
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Warren Holsonback, Vice-President
Brenda Maxwell, Sec/Tres.

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Laura Slade Hudson
803 413-5040
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LauraHudson@SCCVC.org

July 27, 2012

The Honorable Representative Trey Gowdy
2157 Rayburn House Office Building
Washington DC 20515

Dear Representative Gowdy,

As you no doubt would expect, my concern about the growth of Domestic Meth Labs in South Carolina is for the innocent victims of this crime: children and persons buying or renting meth residue contaminated dwellings.

Recent research and testimony by medical professionals has documented that the drug exposed infant may be at risk for problems later in life, such as speech delay, attention deficit hyperactivity disorder and behavioral problems that may not be clinically present until the child is over age two or even school age.

Clandestine labs pose serious threats to child safety and challenge child welfare agencies and communities to develop appropriate protections and treatment strategies for affected families. The South Carolina Department of Alcohol and Other Drug Abuse Services records on their web site an alarming increase in admission rates of Primary, Secondary and Tertiary meth users from 2002 to the present.

Research suggests that methamphetamine users, even with low usage, are easily susceptible to physical, cognitive, and emotional damage which have direct implications for their capacity to protect their children. The lack of pre natal care alone can have devastating results.

Further, the burden on law enforcement, in locating, seizing and processing sites while maintaining safety for officers, social workers and individuals is both a training challenge and a monetary burden on the state.

In a statement by Joseph T. Rannazzisi, Deputy Chief, Office of Enforcement Operations Drug Enforcement Administration *Before the* House Government Reform Committee Subcommittee on Criminal Justice, Drug Policy and Human Resources July 26, 2005, "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies" , he said:

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

clean, healthy, and well-fed. The dogs actually ate off a dinner plate. This scene could have just as easily been found in SC.

Our state Department of Social Services nor our state Victim/Witness Assistance Program are trained or prepared to provide the assistance to victims of methamphetamine, particularly drug endangered children at the level needed to combat the rising "home cooked" brew that is sweeping our state. We need to ensure that all endangered children are identified and that the child's immediate safety is addressed at the scene by appropriate child welfare and health care service providers. Assistance must also be provided to vulnerable adults, individuals of domestic violence, and to customers and employees of businesses such as hotels and motels where methamphetamine has been produced or seized.

The cost of not stopping the sale of precursory ingredients used in this "manufacturing" epidemic within our borders is becoming overwhelming and unmanageable.

The SC Crime Victims' Council joined law enforcement in 2011 to pass legislation to curtail the sale of ephedrine and pseudoephedrine by limiting the amount being sold to individuals and establishing a data base, but "smurfing" has succeeded in bypassing the effectiveness of the law.

Scheduling the precursory drugs will not solve the meth problem in SC, but targeted legislation that restricts the sale of EPH/PSE will help eliminate the domestic meth lab in South Carolina and the nation.

Please help solve this growing epidemic.

For Balancing the Scales,

Laura Hudson
Executive Director

California Border Alliance Group

Southwest Border High Intensity Drug Trafficking Area

David Bejarano
Chief
Chula Vista

Derek Benner
Special Agent in Charge
Dept of Homeland Security
U.S. Immigration & Customs Enforcement
Police Department

Jeffrey A. Calhoon
Chief Patrol Agent
US Bureau of Customs & Border Protection, El Centro Sector

Miguel Colón Jr.
Chief
Imperial Police Department

Leslie P. DeMarco
Special Agent in Charge
Internal Revenue Service
Criminal Investigation, San Diego

The Honorable Laura Duffy
United States Attorney
Southern District of California

The Honorable Bonnie M. Dumanis
District Attorney
San Diego County

William D. Gore
Sheriff
San Diego County

Daphne Hearn
Special Agent in Charge
Federal Bureau of Investigation

Val Jimenez
Special Agent in Charge
California Department of Justice

William M. Lansdowne
Chief
San Diego Police Department

Ray Loera
Sheriff, Coroner, Marshal
Imperial County

Sean M. Mahoney
Captain
U. S. Coast Guard

The Honorable Gilbert G. Otero
District Attorney
Imperial County

William R. Sherman
Special Agent in Charge (Acting)
Drug Enforcement Administration

Steven C. Stafford
U. S. Marshal
United States Marshals Service

July 25, 2012

The Honorable Trey Gowdy
Chairman, Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives
Washington, DC 20515

Re: Pseudoephedrine Controls to Reduce Methamphetamine Labs

Dear Mr. Chairman,

As the Director of the California Border Alliance Group HIDTA (San Diego and Imperial Counties, California,) I strongly support the return of Pseudoephedrine to prescription drug status.

As a member of the National Methamphetamine and Pharmaceuticals Initiative Advisory Board, I have become quite familiar with the issues surrounding the methamphetamine problem throughout the United States, including both Mexico-sourced and domestically-produced meth. Virtually all domestically-produced meth is made from retail-purchased PSE, whether in California super labs run by Mexican drug trafficking organizations, or the epidemic of one-pot labs that plague the Midwest, Southeast, and now the Northeastern states. It is clear to me, and to my Executive Board, that the successes of Oregon and Mississippi in drastically reducing the number of meth labs in those states can be replicated nation-wide by implementing prescription-only PSE on a national basis.

Law Enforcement does not, and will not, have the resources to track down "smurfers," and the continued increase in small toxic labs in much of the country clearly illustrates that computer tracking systems have had no impact in reducing meth labs. Only Oregon and Mississippi have achieved a reduction in lab incidents and all the associated damage – both human and environmental – they entail, and the impact on legitimate patients has been negligible at worst.

I implore the Congress to pass legislation to once again make PSE a prescription drug.

Sincerely,

Kean McAdam
Director

1010 Second Avenue, Suite 1900, San Diego CA 92101-4945
PH: (619) 557-5880 FAX: (619) 557-6450

August 6, 2012

I'll try to make this letter as brief as possible, given how strongly our police department and community feel on this matter, and how many good people have had their lives ruined or ended in the fifteen years since the meth lab epidemic arrived.

CITY OF
TERRE HAUTE
POLICE
DEPARTMENT

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DUKE A. BENNETT
Mayor

JOHN PLASSE
Chief of Police

MARK LEDRES
Assistant Chief / Operations

SHAWN KATS
Assistant Chief / Investigations

The hardest part about getting the proper message across to legislators on the matter of scheduling PSE is getting heard – and actually listened to – over the ceaseless stream of propaganda and distortions being perpetrated by some advocates for the retail and pharmaceutical industry. They pay bloggers to clog up online articles and web sites, they commission "studies" that overstate the importance of PSE while slandering and minimizing the profound success of the two states that have managed to slow their meth lab problem to a trickle by simply rescheduling a non-essential nasal decongestant. Those shameless entities spend millions of dollars on lobbyists and ad campaigns to sway opinions and hide the basic truth.

I can't compete with that, nor can any of the frustrated police officers and prosecutors with whom I have worked to promote the movement to schedule PSE, which we now recognize as the only sensible and effective way to stem the tide of death and destruction that the lab epidemic has created from one coast to the other. You'll be hearing a lot about Mr. Buckstein's Cascade study in the debate surrounding this issue. When you do I would ask that you notice how similar it is to some of the "studies" Big Tobacco used to commission denouncing links between smoking and disease. I would also point out that those of us advocating strongly and passionately for PSE to be re-scheduled (as it was before we let the genie out of the bottle in 1976) are not getting paid a dime to do so. In fact, many of us have dedicated countless hours of our own time, educating community members and legislators, when possible. Those trying to maintain the status quo are profiting to the tune of around 600 million dollars a year from the current sales of PSE. I have no doubt whatsoever that at least two thirds of the PSE sold in Indiana is diverted into methamphetamine. I know this because I have spent more than a decade observing pharmacies and getting to know the pharmacists and pharmacy techs in our community.

One of the most tiresome arguments used by their bloggers and lobbyists is that manufactured meth is only a small percentage of the methamphetamine abused in this country. I readily acknowledge that there is a large market for imported meth and that imported meth makes up a good percentage of what is sold in the United States. HOWEVER, much of the imported methamphetamine is made from illicitly "smurfed" PSE from this country. Also, there is an inherent appeal in the drug culture towards a drug that one can make for themselves. And that meth lab product is more or less pure, instantaneously addictive, and made in environments that are lethally dangerous for anyone in the household or neighborhood. In short, many of the addicts that buy that imported product are addicts because of a manufactured product. And when they don't have money to buy it, meth takes very little money to make.

The tracking of PSE purchases has done absolutely nothing to slow the spread of our lab epidemic throughout Indiana, where our lab numbers continue to escalate, year after year. To use a comparison straight out of pharmaceutical jargon, the tracking of PSE sales is nothing more than a placebo being used to give the appearance that something is actually being done to slow illicit sales. I was one of many who thought it was a good idea ten years ago, but we now have ten years' worth of data showing us that tracking is ineffective. If anything, tracking has created a lot more meth users in our community by raising the black market value of PSE to astronomical levels – anywhere from $50.00 to $80.00 dollars per box, around here. So now a single parent in need of money faces strong temptation to make quick, easy money for a simple, legal, over-the-counter purchase. The problem is that the meth cooker who needs the pills does not always have the cash. What they do always have is methamphetamine. More and more users are created as more and more people are recruited to buy PSE. I've been watching that cycle for years now. We can't monitor all the pharmacies in our community, and tracking data – realtime or otherwise – is nothing more than a record of failure. Is anyone actually suggesting that we can arrest and incarcerate our way out of this epidemic? That's not realistic. This crime has to be prevented before it happens, and Oregon and Mississippi have shown us the way.

Industry shills may try and tell you about "blocked sales," that occur when tracking systems prevent an illicit PSE sale. What they won't tell you is that this system simply helps PSE "smurfers" maximize the yield for each form of identification they use (the use of fake ID's is prevalent – do you want the pharmacy technicians who fill your prescriptions to be distracted by the burden of acting like a police officer?), or by each person they have recruited to buy PSE. They probably won't also mention that pharmacy employees can override the stop if they feel as though they are in danger. Therefore, it becomes possible for the addict to bully or threaten his way into the desired box of PSE. Should we do that for methadone and Oxycontin as well?

We also have a serious problem with prescription drug addiction in this country. And despite having most of those abused drugs on the schedule, they remain highly abused. Why would meth use and manufacture be any different if we schedule PSE? This is an important point in this discussion, and worthy of scrupulous comparison. A Vicodin addict knows just what to say to get the prescription they need from a doctor, or from dozens of doctors, in some cases. Those doctors are not mind readers, and despite skepticism, they are also obligated, to some degree, to treat pain. Pain is a symptom that cannot be disproven. Meth users and addicts, on the other hand, are absolutely terrified of being seen by a doctor. Perhaps this is because that even the least educated among them realize that they are courting death though their meth use, and cannot mask those issues from a doctor whilst simultaneously feigning congestive symptoms that may or may not get then that sought-after PSE prescription.

The majority of the people I know who have been prescribed Vicodin do not finish the prescription. This tells us that most Vicodin users do not become addicted. We have to schedule Vicodin, and most other painkillers, for that matter, for the protection of those users

who would misuse and abuse the drug if it were readily available. Don't be fooled by those hurling rhetoric about the importance of having ready, immediate access to PSE by consumers being an essential "freedom." Controlled substances go on and off of the schedule every year without all of the drama and protest from within the industry. Why the outrage in this instance? Sadly, it is because they are choosing to profit heavily from a ruthless and murderous epidemic. You need look no further than the 75M fine that CVS was forced to pay for knowingly selling PSE to cookers and addicts to get a feel for just how lightly they concern themselves with the explosions, shoot-outs, burned victims, neglected children and hopeless addicts that accompany our meth lab problem. Please keep that in mind the next time you are listening to some lobbyist shamelessly extol the fictional merits of electronic tracking.

You'll be told that the success in Oregon and Mississippi is deceptive, or that it is being falsely presented. And you will most likely be hit over the head with the Cascade study. When that happens please consider an FBI report that shows that Oregon's crime rates are as low as they have been since the 1960's. I would respectfully suggest that believing the Cascade study over the Bureau's crime statistics would be a terrible mistake. Common sense tells us to look at the funding that created that study. As I mentioned earlier, it's no different from some of the bogus research presented by the tobacco industry.

Pseudoephedrine is a non-essential decongestant, and one that almost every doctor I've spoken with would call in for a known patient without an office visit. If you look at the list of contraindications, you see that more than half of the adults in the United States probably shouldn't even be taking PSE (and yet most of them do, because no one takes the time to read the fine print anymore). It's a drug that is doing more harm than good in this country. By far.

I lost a good friend and co-worker, Officer Brent Long, on 7/11/11 when he was shot and killed by a meth cooker using a gun purchased from another meth cooker. Ironically, when he was still alive I once assisted Brent in arresting his own brother for cooking methamphetamine. Brent should not have had to die like that. There are very few people left in our community who have not lost a friend, loved one or acquaintance or co-worker to our meth epidemic. And that epidemic didn't get here until the meth labs did.

This is no longer a problem that we in law enforcement can solve. The only solution, as two states have clearly shown us, is through sensible, logical and proven legislation. Please see through all of the propaganda, big bucks and senseless rhetoric and do the one thing that can stop this needless destruction.

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Sergeant Christian W. Gallagher
Terre Haute Police Department

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