# LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE

## HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

NOVEMBER 18, 2004

**Serial No. 108–287**

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

# LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE

# LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE

## HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

NOVEMBER 18, 2004

**Serial No. 108–287**

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

20–084 PDF WASHINGTON : 2005

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

## COMMITTEE ON GOVERNMENT REFORM

TOM DAVIS, Virginia, *Chairman*

DAN BURTON, Indiana
CHRISTOPHER SHAYS, Connecticut
ILEANA ROS-LEHTINEN, Florida
JOHN M. MCHUGH, New York
JOHN L. MICA, Florida
MARK E. SOUDER, Indiana
STEVEN C. LATOURETTE, Ohio
DOUG OSE, California
RON LEWIS, Kentucky
TODD RUSSELL PLATTS, Pennsylvania
CHRIS CANNON, Utah
ADAM H. PUTNAM, Florida
EDWARD L. SCHROCK, Virginia
JOHN J. DUNCAN, JR., Tennessee
NATHAN DEAL, Georgia
CANDICE S. MILLER, Michigan
TIM MURPHY, Pennsylvania
MICHAEL R. TURNER, Ohio
JOHN R. CARTER, Texas
MARSHA BLACKBURN, Tennessee
PATRICK J. TIBERI, Ohio
KATHERINE HARRIS, Florida
MICHAEL C. BURGESS, Texas

HENRY A. WAXMAN, California
TOM LANTOS, California
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
CAROLYN B. MALONEY, New York
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
DANNY K. DAVIS, Illinois
JOHN F. TIERNEY, Massachusetts
WM. LACY CLAY, Missouri
DIANE E. WATSON, California
STEPHEN F. LYNCH, Massachusetts
CHRIS VAN HOLLEN, Maryland
LINDA T. SANCHEZ, California
C.A. "DUTCH" RUPPERSBERGER, Maryland
ELEANOR HOLMES NORTON, District of Columbia
JIM COOPER, Tennessee
BETTY MCCOLLUM, Minnesota

BERNARD SANDERS, Vermont (Independent)

MELISSA WOJCIAK, *Staff Director*
DAVID MARIN, *Deputy Staff Director/Communications Director*
ROB BORDEN, *Parliamentarian*
TERESA AUSTIN, *Chief Clerk*
PHIL BARNETT, *Minority Chief of Staff/Chief Counsel*

### SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

MARK E. SOUDER, Indiana, *Chairman*

NATHAN DEAL, Georgia
JOHN M. MCHUGH, New York
JOHN L. MICA, Florida
DOUG OSE, California
JOHN R. CARTER, Texas
MARSHA BLACKBURN, Tennessee
PATRICK J. TIBERI, Ohio

ELIJAH E. CUMMINGS, Maryland
DANNY K. DAVIS, Illinois
WM. LACY CLAY, Missouri
LINDA T. SANCHEZ, California
C.A. "DUTCH" RUPPERSBERGER, Maryland
ELEANOR HOLMES NORTON, District of Columbia
BETTY MCCOLLUM, Minnesota

### EX OFFICIO

TOM DAVIS, Virginia

HENRY A. WAXMAN, California

J. MARC WHEAT, *Staff Director*
NICHOLAS COLEMAN, *Professional Staff Member*
MALIA HOLST, *Clerk*
MICHAEL YEAGER, *Minority Deputy Chief Counsel*

# CONTENTS


Page

Hearing held on November 18, 2004 ..... 1

Statement of:

Bundy, Sheriff Steve, Rice County, KS, Sheriff's Department; Lonnie Wright, director, Oklahoma Bureau of Narcotics and Dangerous Drugs; Lieutenant George E. Colby, division commander/project director, Allen County Drug Task Force, Allen County, IN, Sheriff's Department; Joseph Heerens, senior vice president, government affairs, Marsh Supermarkets, Inc., on behalf of the Food Marketing Institute; Dr. Linda Suydam, president, Consumer Healthcare Products Association; and Mary Ann Wagner, vice president, Pharmacy Regulatory Affairs, National Association of Chain Drug Stores ..... 65

Burns, Scott, Deputy Director, State and Local Affairs, Office of National Drug Control Policy; Domingo S. Herraiz, Director, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice; and Joseph Rannazzisi, Deputy Chief, Office of Enforcement, Drug Enforcement Administration ..... 18

Letters, statements, etc., submitted for the record by:

Bundy, Sheriff Steve, Rice County, KS, Sheriff's Department, prepared statement of ..... 68

Burns, Scott, Deputy Director, State and Local Affairs, Office of National Drug Control Policy, prepared statement of ..... 20

Colby, Lieutenant George E., division commander/project director, Allen County Drug Task Force, Allen County, IN, Sheriff's Department, prepared statement of ..... 87

Cummings, Hon. Elijah E., a Representative in Congress from the State of Maryland, prepared statement of ..... 11

Heerens, Joseph, senior vice president, government affairs, Marsh Supermarkets, Inc., on behalf of the Food Marketing Institute, prepared statement of ..... 112

Herraiz, Domingo S., Director, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, prepared statement of ... 29

Rannazzisi, Joseph, Deputy Chief, Office of Enforcement, Drug Enforcement Administration, prepared statement of ..... 44

Souder, Hon. Mark E., a Representative in Congress from the State of Indiana, prepared statement of ..... 5

Suydam, Dr. Linda, president, Consumer Healthcare Products Association, prepared statement of ..... 118

Wagner, Mary Ann, vice president, Pharmacy Regulatory Affairs, National Association of Chain Drug Stores, prepared statement of ..... 124

Wright, Lonnie, director, Oklahoma Bureau of Narcotics and Dangerous Drugs, prepared statement of ..... 79

# LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE

**THURSDAY, NOVEMBER 18, 2004**

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

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2154, Rayburn House Office Building, Hon. Mark E. Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder, Mica, Carter, Tiberi, Moran, Cummings, Norton, and McCollum.

Staff present: J. Marc Wheat, staff director and chief counsel; Nicholas Coleman, professional staff member; Pat DeQuattro, congressional fellow; Malia Holst, clerk; Michael Yeager, minority deputy chief counsel; and Jean Gosa, minority assistant clerk.

Mr. SOUDER. The subcommittee will come to order.

Good morning, and thank you all for coming. Today we continue our subcommittee's work on the problem of methamphetamine trafficking and abuse, a problem that is ravaging the entire Nation and putting a severe strain on law enforcement agencies, particularly at the State and local levels. Many of my colleagues have proposed legislation to help beleaguered law enforcement agencies deal with the meth trafficking threat. Today we hope to examine some of those proposals.

Meth is one of the most powerful and dangerous drugs available, and it is also one of the easiest to make. It can be "cooked" using common household or agricultural chemicals and simple cold medicines, following recipes easily available on the Internet.

Meth comes from two major sources of supply. First, most meth comes from so-called "superlabs" in California and northern Mexico. By the end of the 1990's, these superlabs produced over 70 percent of the Nation's meth supply. Superlabs are operated by large Mexican drug trafficking organizations that have used their established distribution and supply networks to transport meth throughout the country.

The second major source of meth comes from small, local labs that are generally unaffiliated with major trafficking organizations. These labs have proliferated throughout the country. The total amount of meth actually supplied by these labs is comparatively small; however, the environmental damage and health hazard they create makes them a serious problem for local communities, par-

ticularly the State and local law enforcement agencies charged with the duty to uncover and clean them up.

In my home State of Indiana, for example, more than 20 percent of the labs raided by police were discovered only after the labs had exploded and started fires. Children are often found at these meth labs and have frequently suffered from severe health problems as a result of hazardous chemicals used in drug manufacturing. Robberies and violence in local communities as drug dealers and other people seeking money, the addicts, continue to commit criminal acts in order to obtain precursor chemicals and also money to fund their habits. So this has been closely related to other crime in the local communities, much more so than the superlabs.

During this Congress, we have held hearings here in Washington, but we have also held field hearings across the country—in Indiana, Hawaii, the deep south, the northwest—examining the meth epidemic. Everywhere we go, we hear about many of the same issues. In particular, we have heard about the high costs and long hours required for law enforcement agencies to hunt down, investigate, and clean up dangerous meth lab sites, while dealing with the heartbreaking cases of children exposed to drugs and chemicals and in need of emergency medical care and a safe place to go. Where meth is a problem, this drug is probably the single biggest drain on local law enforcement resources in the country.

We will need to take action at every level—Federal, State, and local—to respond to this problem. At other hearings we have addressed the question of treatment and prevention, and Congress will of course need to deal with them. At this hearing, however, we intend to focus on the law enforcement side, specifically what we in Congress can do to help sheriffs and police departments across the Nation deal with meth. The whole meth process started in this subcommittee about probably close to 6 years ago in California, where we started with the superlab problem, and we have increasingly moved to look at the local law enforcement problem, which will be a little more the focus of this hearing.

Congressional proposals to assist local law enforcement have taken two basic forms: first, regulations designed to reduce the supply of precursor chemicals used to make meth; and, second, direct financial assistance to State and local agencies to support anti-meth enforcement. I will briefly discuss each of these concepts.

First, what is the best way to reduce the supply of meth precursor chemicals, such as pseudoephedrine? Presumably, if we can substantially reduce the availability of meth components, the number of small meth labs will be reduced as well. There are several proposals currently on the table intended to do just that.

One idea is to eliminate the Federal "blister pack" exemption for pseudoephedrine sales. Under current law, retailers can sell unlimited quantities of pseudoephedrine, as long as it is packaged in "blister packs." Sadly, these blister packs have not been much of a hindrance to meth cooks. I believe the exemption should be eliminated, and have proposed legislation (H.R. 5347) which would do just that.

A second approach is to put pseudoephedrine and similar chemicals on Schedule V of the Controlled Substances Act. This would force retailers to sell cold medicines and similar products from "be-

hind the counter," and may also force consumers to show identification and sign a register when purchasing such products. It may also prevent non-pharmacists from selling cold medicines. Oklahoma recently enacted this approach in the law, and several other States are planning to do the same. In this session of Congress, Oklahoma Congressman Brad Carson proposed legislation which would do this on a nationwide scale.

Finally, a third approach takes aim at the importation and sale of bulk quantities of pseudoephedrine. According to a recent report in the Oregonian newspaper, most of the world's supply of pseudoephedrine comes from just a few factories in Europe, where, by the way, this subcommittee has been both at Rotterdam and Antwerp, and pressured aggressively European authorities to crack down on the pseudoephedrine shipment, which has traditionally been our supply, as well as working with the Canadians.

But much of this has now moved to India and China. It might be possible to stop most chemical diversion even before these products reach the shores of the United States and the stores in the United States if we can put pressures on the trade. Import quotas, international cooperation, and regulations of the wholesale markets are all possible ways of reducing the availability of precursor chemicals to meth traffickers.

With respect to any new regulation of meth precursors, Congress needs to ask several questions. First, how effective will the new regulation be at reducing the supply of precursors and the number of meth labs? Second, what will be the impact on legitimate sellers and consumers of these products? How much inconvenience do we want to impose on people who just want to buy cold medicines? And, finally, how effective will the regulations passed only in one State be if all the other States don't follow suit? Do we need a national standard?

The second set of proposals involves Federal grants and other financial assistance to State and local law enforcement agencies. Currently, the Federal Government provides significant assistance to State and local agencies through several grant programs, including the Byrne Grants and the COPS "Meth Hot Spots" grants, administered by the Department of Justice, and the High Intensity Drug Trafficking Areas [HIDTA] program, administered by the Office of National Drug Control Policy [ONDCP].

State and local law enforcement officials have repeatedly told me and my staff that these grants are vital to their drug enforcement, and particularly their meth enforcement efforts. Several Members of Congress, including Missouri Congressman and Majority Whip Roy Blunt and my subcommittee colleague from California Doug Ose, have proposed expanding these programs to deal with the meth threat. The administration, however, has proposed significant cuts in these programs particularly the Byrne Grants. Before deciding whether to expand, contract, or significantly re-tailor these programs, Congress needs to have a better understanding of what they do and how effective they are.

This hearing will address these difficult questions and hopefully help lay the groundwork for legislative action in the next Congress. Our first panel of witnesses has joined us to discuss the Federal Government's response to the meth problem. Mr. Scott Burns, Dep-

uty Director of State and Local Affairs at the Office of National Drug Control Policy, who has taken a lead role in addressing meth issues; Mr. Domingo Herraiz, Director of the Bureau of Justice Assistance at the Justice Department's Office of Justice Programs, which is responsible for administering many of the Federal grant proposals at issue today; and Mr. Joseph Rannazzisi, Deputy Chief of the Office of Enforcement at the Drug Enforcement Administration, which is not only responsible for coordinating the Federal Government's meth enforcement efforts, but also for administering the Federal Government's meth cleanup assistance program for State and local agencies.

For the record, the subcommittee invited the U.S. Coast Guard to testify at this hearing concerning the trafficking of Southeast Asian methamphetamine, also called yaba, and the movement of precursor chemicals into this country from Asia. The Coast Guard declined to testify about their knowledge of these issues. The subcommittee will ask the Coast Guard in writing about questions regarding Southeast Asian meth and the movement of precursor chemicals.

At a hearing like this, it is vitally important for us to hear from the State and local agencies forced to fight on the "front lines" against meth and other illegal drugs. We welcome Mr. Lonnie Wright, Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs, who will talk to us today about his State's new anti-meth law; Sheriff Steve Bundy of the Rice County, KS Sheriff's Department; my fellow Hoosier, Lieutenant George Colby, Division Commander and Project Director of the Allen County Drug Task Force at the Allen County Sheriff's Department.

We also welcome three representatives of manufacturers and retailers of pseudoephedrine products, who will help us understand the impact that new regulations may have on businesses and consumers. We are joined by Mr. Joseph Heerens, Senior Vice President for Government Affairs at Marsh Supermarkets, on behalf of the Food Marketing Institute; Dr. Linda Suydam, President of the Consumer Healthcare Products Association; and Ms. Mary Ann Wagner, Vice President for Pharmacy Regulatory Affairs at the National Association of Chain Drug Stores.

We thank everyone for taking the time to join us this morning, and look forward to your testimony.

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

Opening Statement
Chairman Mark Souder

"Law Enforcement and the Fight Against Methamphetamine"

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

November 18, 2004

Good morning, and thank you all for coming. Today we continue our Subcommittee's work on the problem of methamphetamine trafficking and abuse – a problem that is ravaging the entire nation and putting a severe strain on law enforcement agencies, particularly at the state and local levels. Many of my colleagues have proposed legislation to help beleaguered law enforcement agencies deal with the meth trafficking threat. Today, we hope to examine some of those proposals.

Meth is one of the most powerful and dangerous drugs available, and it also one of the easiest to make. It can be "cooked" using common household or agricultural chemicals and simple cold medicines, following recipes easily available on the Internet. Meth comes from two major sources of supply. First, most meth comes from the so-called "superlabs" in California and northern Mexico. By the end of the 1990's these superlabs produced over 70 percent of the nation's supply of meth. The superlabs are operated by large Mexican drug trafficking organizations that have used their established distribution and supply networks to transport meth throughout the country.

The second major source of meth comes from small, local labs that are generally unaffiliated with major trafficking organizations. These labs have proliferated throughout the country. The total amount of meth actually supplied by these labs is relatively small; however, the environmental damage and health hazard they create make them a serious problem for local communities, particularly the state and local law enforcement agencies charged with the duty to uncover and clean them up. In my home state of Indiana, for example, more than 20% of the labs raided by police were discovered only after the labs had exploded and started fires. Children are often found at meth labs, and have frequently suffered from severe health problems as a result of the hazardous chemicals used in drug manufacturing.

During this Congress, we have held field hearings throughout the country – from Indiana to Hawaii – examining the meth epidemic. Everywhere we go, we hear about many of the same issues. In particular, we have heard about the high

costs and long hours required for law enforcement agencies to hunt down, investigate, and clean up dangerous meth lab sites, while dealing with the heartbreaking cases of children exposed to drugs and chemicals and in need of emergency medical care and a safe place to go. This drug is probably the single biggest drain on law enforcement resources in the country.

We will need to take action at every level – federal, state and local – to respond to this problem. At other hearings, we have addressed the question of treatment and prevention – and Congress will of course need to deal with them. At this hearing, however, we intend to focus on the law enforcement side – specifically, what we in Congress can do to help sheriffs' and police departments across the nation deal with meth.

Congressional proposals to assist law enforcement have taken two basic forms: first, regulations designed to reduce the supply of precursor chemicals used to make meth; and second, direct financial assistance to state and local agencies to support anti-meth enforcement. I will briefly discuss each of these concepts.

First, what is the best way to reduce the supply of meth precursor chemicals, such as pseudoephedrine? Presumably, if we can substantially reduce the availability of meth components, the number of small meth labs will be reduced as well. There are several proposals currently on the table intended to do just that. One idea is to eliminate the federal "blister pack" exemption for pseudoephedrine sales. Under current law, retailers can sell unlimited quantities of pseudoephedrine, as long as it is packaged in "blister packs." Sadly, these blister packs have not been much of a hindrance to meth cooks. I believe the exemption should be eliminated, and I have proposed legislation (H.R. 5347) which would do just that.

A second approach is to put pseudoephedrine and similar chemicals on Schedule V of the Controlled Substances Act. This would force retailers to sell cold medicines and similar products from "behind the counter," and may also force consumers to show identification and sign a register when purchasing such products. It may also prevent non-pharmacists from selling cold medicines. Oklahoma recently enacted this approach into law, and several other states are planning to do the same; Congressman Brad Carson has proposed legislation which would do this on a nationwide scale.

Finally, a third approach takes aim at the importation and sale of bulk quantities of pseudoephedrine. According to a recent report in The Oregonian newspaper, most of the world's supply of pseudoephedrine comes from just a few factories in Europe, India, and now China. It might be possible to stop most chemical diversion even before these products reach the stores. Import quotas, international cooperation, and regulations of the wholesale markets are all

possible ways of reducing the availability of precursor chemicals to meth traffickers.

With respect to any new regulation of meth precursors, Congress needs to ask several questions. First, how effective will the new regulation be at reducing the supply of precursors and the number of meth labs? Second, what will be impact on legitimate sellers and consumers of these products? How much inconvenience do we want to impose on people who just want to buy cold medicines? And finally, how effective will regulations passed only in one state be – if all the other states don't follow suit? Do we need a national standard?

The second set of proposals involves federal grants and other financial assistance to state and local law enforcement agencies. Currently, the federal government provides significant assistance to state and local agencies through several grant programs, including the Byrne Grants and the COPS "Meth Hot Spots" grants, administered by the Department of Justice, and the High Intensity Drug Trafficking Areas (HIDTA) program, administered by the Office of National Drug Control Policy (ONDCP).

State and local law enforcement officials have repeatedly told me and my staff that these grants are vital to their drug enforcement, and particularly their meth enforcement, efforts. Several members of Congress (including Congressman Roy Blunt and my Subcommittee colleague Congressman Doug Ose) have proposed expanding these programs to deal with the meth threat. The Administration, however, has proposed significant cuts in these programs – particularly the Byrne Grants. Before deciding whether to expand, contract, or significantly retailor these programs, Congress needs to have a better understanding of what they do and how effective they are.

This hearing will address these difficult questions and hopefully help lay the groundwork for legislative action in the next Congress. Our first panel of witnesses have joined us to discuss the federal government's response to the meth problem: Mr. Scott Burns, Deputy Director for State and Local Affairs at the Office of National Drug Control Policy (ONDCP), who has taken a lead role in addressing meth issues; Mr. Domingo S. Herraiz, Director of the Bureau of Justice Assistance at the Justice Department's Office of Justice Programs (OJP), which is responsible for administering many of the federal grant programs at issue here; and Mr. Joseph Rannazzisi, Deputy Chief of the Office of Enforcement at the Drug Enforcement Administration (DEA), which is not only responsible for coordinating the federal government's meth enforcement efforts, but also for administering the federal government's meth cleanup assistance program for state and local agencies.

For the record, the Subcommittee invited the U.S. Coast Guard to testify at this hearing concerning the trafficking of Southeast Asian methamphetamine (also called "yaba"), and the movement of precursor chemicals into this country.

The Coast Guard declined to testify about their knowledge of these issues. The Subcommittee will ask the Coast Guard in writing about questions regarding Southeast Asian meth and the movement of precursor chemicals.

At a hearing like this, it is vitally important for us to hear from the state and local agencies forced to fight on the "front lines" against meth and other illegal drugs. We welcome Mr. Lonnie Wright, Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs, who will talk to us today about his state's new anti-meth law; Sheriff Steve Bundy of the Rice County, Kansas Sheriff's Department; and my fellow Hoosier, Lt. George E. Colby, Division Commander and Project Director of the Allen County Drug Task Force, at the Allen County, Indiana Sheriff's Department.

We also welcome three representatives of the manufacturers and retailers of pseudoephedrine products, who will help us understand the impact that new regulations may have on businesses and consumers. We are joined by Mr. Joseph Herrens, Senior Vice President for Government Affairs at Marsh Supermarkets, Inc., on behalf of the Food Marketing Institute; Dr. Linda Suydam, President of the Consumer Healthcare Products Association (CHPA); and Ms. Mary Ann Wagner, Vice President for Pharmacy Regulatory Affairs at the National Association of Chain Drug Stores. We thank everyone for taking the time to join us this morning, and look forward to your testimony.

Mr. SOUDER. Now I will yield to the distinguished ranking member, Mr. Elijah Cummings.

Mr. CUMMINGS. I want to thank you, Mr. Chairman, for holding this hearing and for your attention to this important issue of methamphetamine abuse in the United States and our efforts to fight it.

Methamphetamine is a dangerous, highly addictive, and sometimes deadly illegal drug, the increasing use of which has created a serious drug epidemic in our country.

Once concentrated in the western United States and among particular population subgroups, the use of meth has spread geographically, has become more broadly population, and appears to be increasing among young adults in particular. Significant changes in patterns of meth trafficking and production have contributed to the epidemic, while increasing the challenge of anti-meth law enforcement efforts.

The adverse impact of the meth problem is not limited to the serious negative effects on health and the general well-being of its users. Because meth use leads to violent and erratic behavior, it fuels serious crime problems in areas where meth use is prevalent; and meth production can result in deadly exposures and substantial environmental damage. For these reasons, the spread of meth production and use creates severe burdens for the government agencies that must deal with the consequences.

On that note, I want to thank all of our witnesses who, on a day-to-day basis, work so hard to address the drug problems in this country. As one who has seen the effects of the drug epidemic and has seen the people that it has destroyed, the neighborhoods and the families, I thank you for what you are trying to do. I know it is an awesome task.

Anti-meth efforts have become an increasing focus for Federal, State, and local law enforcement agencies in various parts of the country, including through the High Intensity Drug Trafficking Areas program and other joint law enforcement task forces.

We will hear today from representatives of the Office of National Drug Control Policy, the Drug Enforcement Administration, the Office of Justice Programs, and the drug law enforcement officials from Indiana, Kansas, and Oklahoma about how law enforcement is responding to the trends in meth production, trafficking, and use, and to the costly consequences of these activities.

The chairman did mention the fact that we will be hearing about the Federal Government's response. One of the things I am also interested in hearing is I read about some of the State laws that have been put into effect, and I would like to hear recommendations as to whether other States should be doing the same things, or perhaps whether the Federal Government should step up their role in regard to those issues.

When I read about one of them, I immediately wrote my State legislator, my favorite State legislator—you have always got to have somebody to carry your water in the State government—and said, look, you ought to put this into effect; you ought to make sure you file this come January, when our legislature comes into being. So we want to know that.

Because meth is frequently manufactured from common, readily available products, such as over-the-counter cold and cough medicines, it presents unique policy problems. Beginning with the Comprehensive Methamphetamine Control Act of 1996, Congress has responded with legislation to increase penalties for meth-related crimes and tightened controls on retail sales of products containing pseudoephedrine and related chemicals. Several proposals introduced in the 108th Congress would place further restrictions on the sale of over-the-counter products' use in meth production, and Mr. Souder has gone over some of them.

Clearly, the meth epidemic presents a difficult set of challenges for law enforcement policymakers. I hope today's hearing will enhance our understanding of the challenges and shed some light on what further action we should take to address the problem.

And I want all of our witnesses to know that this is indeed a bipartisan subcommittee, and we share a lot of concerns with regard to drugs, and we have worked very hard to make sure the government works effectively and efficiently using the taxpayers' dollars to address those problems. So we welcome you; we thank you.

With that, Mr. Chairman, I yield back.

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

**Representative Elijah E. Cummings, Maryland-7**
**Ranking Minority Member**
**Subcommittee on Criminal Justice, Drug Policy, and Human Resources**
**Committee on Government Reform**
**U.S. House of Representatives**
**108th Congress**

**Hearing on "Law Enforcement and the Fight Against Methamphetamine"**

**November 17, 2004**

Mr. Chairman,

Thank you for holding this hearing and for your attention to the important issue of methamphetamine abuse in the United States and our efforts to fight it.

Methamphetamine is a dangerous, highly addictive, and sometimes deadly illegal drug, the increasing use of which has created a serious drug epidemic in our country.

Once concentrated in the Western United States and among particular population subgroups, the use of meth has spread geographically, has become more broadly popular, and appears to be increasing among young adults, in particular. Significant changes in patterns of meth trafficking and production have contributed to the epidemic while increasing the challenge to anti-meth law enforcement efforts.

The adverse impact of the meth problem is not limited to the serious negative effects on the health and general well-being of users. Because meth use leads to violent and erratic behavior, it fuels serious crime problems in areas where meth use is prevalent; and meth production (often in makeshift clandestine labs) can result in deadly explosions and substantial environmental damage. For these reasons, the spread of meth production and use creates severe burdens for the government agencies that must deal with the consequences.

Anti-meth efforts have become an increasing focus for federal, state and local law enforcement agencies in various parts of the country, including through the High Intensity Drug Trafficking Areas program and other joint law enforcement task forces.

We will hear today from representatives of the Office of National Drug Control Policy, the Drug Enforcement Administration, the Office of Justice Programs, and drug law enforcement officials from Indiana, Kansas, and Oklahoma about how law enforcement is responding to the trends in meth production, trafficking, and use, and to the costly consequences of these activities.

Because meth is frequently manufactured from common, readily available products such as over-the-counter cold and cough medicines, it presents unique policy problems. Beginning with the Comprehensive Methamphetamine Control Act of 1996, Congress has responded with legislation to increase penalties for meth-related crimes and tighten controls on retail sales of products containing pseudoephedrine and related chemicals. Several proposals introduced in the 108th Congress would place further restrictions on the sale of over-the-counter products used in meth production and we will hear testimony concerning the likely impact of these proposals on law enforcement, consumers, and the retail industry.

Clearly, the meth epidemic presents a difficult set of challenges for law enforcement and policymakers. I hope today's hearing will enhance our understanding of the challenges and shed some light on what further action Congress should take to address the problem.

I look forward to hearing the testimony of our witnesses and yield back the balance of my time.

##

Mr. SOUDER. Mr. Mica, did you have an opening statement?

Mr. MICA. Well, Mr. Chairman and ranking member, I thank you for convening this hearing today on law enforcement's efforts and the administration's efforts to fight the scourge of meth abuse and misuse of illegal narcotics. Having participated on this panel for some time—and I think I just heard the chairman recall a hearing that we held in California, when we saw the beginning of this problem in our country—I think I was never so shocked as some of the testimony we heard. I think one was of a mother who put her baby in a microwave when she was on meth, and we heard social workers talking about dozens of children that had been abandoned because their parents or guardian was hooked on meth.

It made me realize that we had a very insidious problem, and also a problem that needed a multifaceted approach, and I am pleased the administration has what they call a national synthetic drugs action plan. One of the realizations from that hearing and from that time was that it is going to take a combination of effort. It is not just enforcement, which is important; it is not just interdiction of the chemicals, because meth can be produced with off-the-shelf ingredients; it is going to take education and treatment efforts.

And I think people really don't realize and, fortunately, hearings like this can tell the damage that this is doing. Right now we are in the 20,000 range per year of individuals who die from drug overdose deaths; 20,000 Americans. It is a phenomenal number; it is a silent death. But that is only those from drug overdose. You are not talking about the murders, the suicides; you are not talking about the human toll, the families that are in total chaos and individual lives that are destroyed through narcotics. This is indeed our biggest social problem, the biggest problem in our society today, is the problem of illegal narcotics, now led by the meth epidemic.

So I think you are holding the hearing today is important, and I think that the plan of action that has been proposed is important, and I think that we need to provide whatever resources are necessary in a concerted effort to deal, again, with this whole situation.

So I thank you and I look forward to working with you, and applaud your efforts today in bringing this to the attention of the subcommittee and Congress.

Mr. SOUDER. Thank you.

Ms. Norton, do you have any opening comments?

Ms. NORTON. Thank you very much, Mr. Chairman. I appreciate this hearing.

It is not the first hearing we have had on methamphetamine, and I think the fact that we have had more than 1 year points out the concern of the committee and the Congress about the rapid spread of this drug, whose effects are quite pervasive, not only on individuals, but on the environment itself, because these labs require extensive cleanup after they are brought down.

I recognize that drugs of choice differ based on location in the country, and that in big cities you don't hear as much about meth. You hear about very dangerous drugs, but not meth. And it is interesting, I guess whoever establishes a niche, that becomes the drug of that locale.

But I asked about meth in the Nation's Capital, and, yes, to be sure, it is the kind of drug where the existence of labs and the like do not lend themselves as readily to bringing it in to the middle of a big city, so it is not a major problem here yet. I am very concerned that we catch it, because who it is a major problem with are teenagers and young adults.

And we know about the use of young adults and the distribution at raves and at nightclubs of meth and meth-type drugs. So I am particularly concerned about the age group that is involved and that this could sweep everywhere. We already, it seems to me, have a major problem with meth, but it would appear to me that it has real attraction on a national level.

There are a number of bills that have been pending for sometime in the Congress. The last time we took, I think, significant action was in the 106th Congress. I don't believe these bills are terribly controversial, and I certainly hope some of them will come to the floor.

For example, a bill that would require that certain of the ingredients that can be used to make meth, which are readily available in a store or a drug store, be kept behind the counter of the pharmacy, so that you would have to make your purchase over the counter and show identification and sign a log. I think these are the kind of minimal steps that the Congress should take. At the same time that we are saying to drug enforcement officers around the country why don't you clean it up, we need to do all we can, and perhaps much more, to help you clean it up.

Thank you very much, Mr. Chairman.

Mr. SOUDER. Thank you.

Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman. Thank you for having this hearing today. It is a real pleasure to have a constituent of mine on the panel, and friend, Domingo Herraiz, who has, in the past, served Ohio as the man in charge of the Criminal Justice Service Office in Ohio. Great reputation; did a great job in Ohio. Thank you for your work here in Washington and your service to our country.

I yield back.

Mr. SOUDER. Thank you.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

This is a hearing that I think will help us be more effective in working with you and our local law enforcement on this very critical issue of methamphetamine. I just had some law enforcement in my office on Monday from our Minnesota Police and Peace Officers Association, and we have taken some of the steps to work toward reducing the number of small labs. Prompts come up when Sudafed is purchased and that, but law enforcement was sharing with me that the bigger problem—and it is in the testimony that is before us today—is really from the major labs that are producing methamphetamine in very large quantities.

Law enforcement spoke of three generations of methamphetamine abusers in one family, and now arresting the grandchildren of meth users. So this is a very serious problem which needs to be looked at. The filling up of our prisons in Minnesota, as we do

make arrests; the lack of any kind of treatment that is proven to help people who do want to change their life around is very serious.

But I think the issue that concerned me most was the first responders and their concern about their own personal health. So I think if this is part of the war on drugs, we need to come up with protocols for what type of equipment will be available for rural, urban, and suburban first responders; what is the protocol when we find children for their health, well-being, which affects their ability to be good learners in school; and what we are going to do for our first responders for their health. We are now starting to see retirements come about as people literally have had their lungs destroyed when they have encountered labs that they didn't know that they were walking into.

So, Mr. Chair, I appreciate the hearing and I look forward to working on this very important issue.

Mr. SOUDER. Thank you.

Judge Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Well, I first encountered speed back in 1981. As a trial judge, we dealt with it a lot. I had an experience that I will share with you one time. We had a bunch of trustees that were moving furniture in the courthouse, and I was just listening to their conversation, and I discovered something that was very interesting: going to prison is the cost of doing business in the drug manufacturing business. If going to prison is not too harsh and the profits are great, then the results are that it is just the cost of doing business, and 2 or 3 years is not bad when you are making a million bucks a year, so you just take your time and go back, and you are back in business in 30 days and everything is wonderful.

Now, we weren't dealing with the superlabs that you are dealing with today; we were dealing with the mom-and-pop operations. But, first off, an information program went out through the local papers about the problems with meth and the problems with speed, and what happens when kids get on it; and then the jury showed up and started issuing punishment, because in Texas you get to go to the jury for punishment.

And people discovered that maximum sentences for those people who were manufacturing methamphetamine resulted, at least in our county, of no manufacture of methamphetamine. Methamphetamine generally, in those days, was manufactured in the suburban counties around the urban areas, and we happened to qualify as one of those suburban counties around Austin being the urban area. They weren't cooking meth in Austin; they were cooking meth in Williamson County and Bastrop County and Hays County and Bernard County that surrounded Austin. Within 60 days there wasn't anybody cooking in Williamson County, because everybody that got caught was going to prison for 20 years and up. And ultimately that problem got solved in our area, because everybody started looking at what happened.

So I want to know what we are doing in the way of punishing people who are manufacturing this stuff, because I happen to believe that if the cost of doing business gets great enough, on the mom-and-pop labs, at least, the speed labs go elsewhere. And then ultimately we need to know what is being done internationally on

these people that are cooking out of this country, and the harshness that we are dealing with those people who are transporting into this country large volumes of these drugs, because I think that also has a cost of doing business effect on drug traffic.

I agree with everything that everyone says about the issue of treating people, but the bottom line is education. Making the business difficult, in my opinion, is the key to cleaning up the drug business. So I would like to hear your ideas on some of those things, and I thank you very much for being willing to come here and share with us.

Mr. SOUDER. Thank you.

We are going to insert into the record this tremendous Oregonian newspaper series, "Unnecessary Epidemic," that has a very interesting map that shows, as this committee has watched it over the years, the track from west to east of the meth problem, starting in Hawaii, which is the oldest and deepest. We are now in the city of Honolulu. Some apartment complexes require cleaning prior to taking occupancy, because the leftover meth chemicals from the labs poison the children in the next group that comes in. We have seen it in the west coast, moving to the midwest. You can tell by the request for field hearings to this committee. Right now they are outstanding from members, from Kansas, Missouri, Kentucky, southern Indiana, Tennessee, and North Carolina.

And the hearing requests tend to come as it is moving east. We get the request from that group of members, and you can see the intensity of the problem coming. In the Speaker's drug task force, it is the No. 1 subject that comes up. The members from North Carolina showed up en masse last time regarding the meth problem as it has moved.

As we have held the field hearings, we have seen the first signs of it coming into motels and other things in New Orleans, and in the southeast, Detroit, which would be the first hit in some of the largest cities, because up until now it tends to have been a rural phenomenon and to some degree moving into the suburbs.

If it hits the cities, it could be like a crack epidemic, which is why we really need to work at both the rural and the urban side, and understand that this is something that is a widening threat; and when it hits a district, to the Member of Congress in that district, it becomes the No. 1 issue in his district, beyond any other narcotics issue.

With that, we will have a few other things we are going to insert, but before proceeding, I want to take care of a couple of procedural matters. First, I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record; that any answers to written questions provided by the witnesses also be included in the record. Without objection, it is so ordered.

I also ask unanimous consent that all exhibits, documents, and other materials referred to by Members and the witnesses may be included in the hearing record, and that all Members may be permitted to revise and extend their remarks. Without objection, it is so ordered.

Now, our first panel, Mr. Burns, Mr. Herraiz, and Mr. Rannazzisi, if you will stand and raise your right hands, I will ad-

minister the oath. It is the tradition of this committee, as you know, because it is an oversight committee, that it is our standard practice to ask all witnesses to testify under oath.

[Witnesses sworn.]

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

Mr. Scott Burns, Deputy Director at ONDCP. And we are also going to insert into the record your National Synthetic Drugs Action Plan. As we look into the next session, and what we can do here in Congress, this will give us a good layout. You have done a good job of pulling that together, and we look forward to hearing your summary of those remarks and what you have been working on in this area; and thank you for your leadership at the State and local level.

**STATEMENTS OF SCOTT BURNS, DEPUTY DIRECTOR, STATE AND LOCAL AFFAIRS, OFFICE OF NATIONAL DRUG CONTROL POLICY; DOMINGO S. HERRAIZ, DIRECTOR, BUREAU OF JUSTICE ASSISTANCE, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE; AND JOSEPH RANNAZZISI, DEPUTY CHIEF, OFFICE OF ENFORCEMENT, DRUG ENFORCEMENT ADMINISTRATION**

Mr. BURNS. Well, thank you, Chairman Souder, Ranking Member Cummings, and members of the subcommittee. Thank you for the opportunity to appear before you today to discuss the efforts to reduce the problem of methamphetamine in America. I appreciate this subcommittee's longstanding support of the Office of National Drug Control Policies and our efforts against illegal drug use.

The problem of methamphetamine use, distribution, and production, as you know and have discussed, is one with which I am also well acquainted. I was a prosecutor in rural Utah for some 16 years before being confirmed in my present position. Methamphetamine use and labs can take a significant toll on communities, but I am pleased to report that there is good news on the horizon. As discussed in the administration's newly released National Synthetic Drugs Action Plan, there are things we can do that we know will make the methamphetamine problem smaller and that we intend to pursue over the next 4 years.

My written testimony discusses this in greater detail, and I request it be made part of the record.

Our approach to methamphetamine must be market-based, focusing both on the supply and demand of the drug. Reducing the supply of methamphetamine is best accomplished by destroying the ability of methamphetamine cooks, both large and small, to make the final product; and this means making the acquisition of chemicals used to cook methamphetamine even harder than it is now.

One of our successes in this area is Operation Northern Star, which is a DEA-led initiative to cutoff the supply to superlabs of pseudoephedrine, the key ingredient, again, as you know, used to make meth. By focusing on the diversion of these chemicals from Canada to domestic superlabs, we have now seen a shrinking in the number of superlabs within the United States, and that is good news. However, we believe that some of these superlabs are being pushed south of our borders to Mexico; and for this reason we will

continue to work with our international partners, such as the Fox administration, to stop the flow of these chemicals into Mexico, and we fully support the efforts of the Fox administration to become more effective in controlling the methamphetamine threat in Mexico.

In addition to the efforts of Federal law enforcement, we continue to be focused on disrupting the domestic market for methamphetamine. For example, the percentage of Organized Crime Drug Enforcement Task Force, or OCDETF, investigations in which at least one of the drugs involved included methamphetamine has steadily increased, from 19.2 percent in fiscal year 2001 to 26.7 percent in fiscal year 2004.

Additionally, among the High Intensity Drug Trafficking Area, or HIDTA, initiatives that focus predominantly on a single drug, more have focused on methamphetamine than any other drug. Most of the remaining initiatives which were poly drug in nature included a methamphetamine focus.

Among the many recommendations of the administration's Synthetic Drug Action Plan are those designed to cutoff access by methamphetamine producers to precursors such as pseudoephedrine. These including a lowering of the Federal limit on single sales of pseudoephedrine products and removing the so-called blister pack exemption that currently exists in Federal law.

Federal legislation will be necessary to implement some of the recommendations set forth in the Action Plan, and we look forward to working with you to identify the right solutions. Additionally, some States have focused on limiting not only the amount of pseudoephedrine products that may be purchased, but also the location and manner in which the product may be purchased, and have imposed additional requirements for the process of the purchase itself.

Over the next several months we will be closely analyzing the data and results in States where these innovative measures have been implemented. Many of these State actions were taken in the recent past, so over the next several months we will seek the best data and information possible to highlight which of those approaches are the most effective in reducing methamphetamine availability and lab numbers.

In conclusion, as with the drug issue as a whole, it is important to remember that drug trafficking and production respond to effective supply and demand reduction measures, and the administration looks forward to working with Congress to effectuate a lasting reduction of the methamphetamine problem in America.

I look forward to your questions and, again, thank you for holding this hearing.

[The prepared statement of Mr. Burns follows:]

**Statement by Scott Burns**
**Deputy Director for State and Local Affairs**
**Office of National Drug Control Policy**
**Before the House Committee on Government Reform**
**Subcommittee on Criminal Justice, Drug Policy, and Human Resources**
**November 18, 2004**
**"Law Enforcement and the Fight Against Methamphetamine"**

Chairman Souder, Ranking Member Cummings, and Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss efforts to reduce the problem of methamphetamine in America. The issue is one with which I am well acquainted. Prior to being nominated and confirmed in my present position, I worked as an elected prosecutor in a rural county, where methamphetamine use, sales, and production were a problem. Prosecutors and police in areas where methamphetamine is a problem know too well the toll that methamphetamine production and use take on both individuals and their community. In short, the consequences to individual health and the associated criminal activity as well as the environmental and economic harm, can be devastating.

Fortunately, there is good news. We have recently seen some encouraging results from new methods of attacking the methamphetamine trade. And the Administration's newly released "National Synthetic Drugs Action Plan," which I will discuss here in more detail, is a comprehensive approach designed to weaken the supply of, and the demand for, methamphetamine in the United States. In my testimony today, I will highlight relevant parts of the action plan, and outline the tasks that we intend to accomplish over the next four years to continue to reduce the methamphetamine problem in America.

**Describing the Market**

Any supply reduction strategy for methamphetamine must first inquire as to the source of the drug. Available information regarding the amount of methamphetamine seized from methamphetamine laboratories of varying sizes suggests that most of the methamphetamine consumed in the United States is likely to originate from "superlabs" (laboratories with a daily production capacity exceeding 10 pounds), and either smuggled into the United States from outside of our borders, or produced within our borders, often by Mexican criminal organizations. Similarly, we believe that a smaller amount is produced in smaller quantities at "small toxic laboratories" (STLs), which can be found in residences, vehicles, and makeshift structures. Attacking the supply from both sources is important, but each requires a somewhat different approach.

**Administration Efforts**

With respect to the superlabs described above, law enforcement efforts have aimed to cut off the supply of pseudoephedrine, the principal ingredient (or precursor), used to

produce methamphetamine. In recent years, the supply came primarily via Canadian suppliers to domestic superlab operators. Law enforcement efforts to disrupt the diversion of these chemicals from Canada have been coordinated in Operation Northern Star, led on the American side by DEA, with participation by US Immigration and Customs Enforcement, and closely coordinated with the Royal Canadian Mounted Police (RCMP). Canada's implementation of controls on the importation of precursor chemicals was also a critical element in stopping the flow of chemicals into Canada. In a sign that these efforts are having a real impact, the number of superlab seizures within the United States has substantially declined since the initiative's inception in 2001. Other indicators suggesting that Operation Northern Star has contributed to shrinking the illicit pseudoephedrine market include a decline in pseudoephedrine and ephedrine incidents at the Canadian border by 85% and a doubling in the price of bulk pseudoephedrine in the illicit market in California, the state with the most superlabs. Arrests and prosecutions are the main drivers of these market changes: in April 2003, the DEA and RCMP announced the arrest of over 65 individuals in 10 cities throughout the US and Canada, and just last month, the DEA arrested an additional 90 methamphetamine and ephedrine traffickers in a single operation.

Along with the reduction in domestic superlabs, it appears that the decline in chemical trafficking to Canada has caused some chemical suppliers to seek to ship the chemicals to Mexico instead, where law enforcement believes the number of labs is increasing. Consistent with these changes to the illicit pseudoephedrine market, methamphetamine seizures at the shared border with Mexico rose from 1,172 kilograms in 2001 and 1,224 kilograms in 2002 to 1,735 kilograms in 2003.

For this reason, the Administration will continue to work with our international partners to stop the flow of bulk pseudoephedrine and ephedrine into Mexico, through bilateral chemical control cooperation and multilateral cooperation with the international chemical industry. We particularly acknowledge the leadership of the Fox administration in seeking mechanisms to control the methamphetamine threat in Mexico. We fully support their efforts to become more effective at identifying and dismantling labs on their side of the border. During the week of November 8, 2004, US Immigration and Customs Enforcement agents, in coordination with DEA, dismantled a major Mexican smuggling organization that was smuggling precursor chemicals and finished methamphetamine into the United States from Mexico. During the course of this Organized Crime Drug Enforcement Task Force (OCDETF) investigation, agents seized 1,100 pounds of iodine, 37 gallons of hypophosphorous acid and 25 gallons of hydriodic acid – all of which are precursors used in the methamphetamine production process – at or shortly after crossing the border. The DEA Southwest Laboratory has calculated that this quantity of chemicals could have been used toward the production of approximately 550 pounds of methamphetamine.

Currently, the United States is involved in several multilateral initiatives to track chemicals used in the manufacture of amphetamines, methamphetamine, and other amphetamine-type stimulants such as 3,4 methlyenedioxymethamphetamine (MDMA) and other synthetics, with the goal of enhancing the involvement of China, India, the

Netherlands, Canada, Mexico, Poland, the Czech Republic, and other countries in cooperative chemical control efforts.

In addition, the efforts of Federal law enforcement agencies and programs continue to be focused on disrupting the domestic market for methamphetamine. The percentage of Organized Crime Drug Enforcement Task Force (OCDETF) investigations in which at least one of the drugs involved included methamphetamine increased from 19.2% in FY 2001 to 25.1% in FY 2002. The program's methamphetamine focus has continued to increase since then, to 25.9% in FY 2003 and 26.7% in FY 2004. OCDETF investigations which involve methamphetamine are particularly prevalent in three of the nine OCDETF regions – West-Central, where 53.1% of the investigations involve methamphetamine; Southwest, with 58.8%; and Pacific, with 45.8%.

The High Intensity Drug Trafficking Area (HIDTA) program also provides a valuable means for Federal, state and local law enforcement to collaborate against mid- and high-level methamphetamine traffickers in regions where methamphetamine is a significant threat. The purpose of the program is to enhance and facilitate the cooperation between Federal, state and local law enforcement agencies. All HIDTAs develop local initiatives designed to respond to the threat in their area. In recent years, among HIDTA initiatives that focused predominately on a single drug, more have focused on methamphetamine than on any other drug. And most of the remaining initiatives which were poly-drug in nature included a methamphetamine focus.

As one example of a successful methamphetamine-related HIDTA initiative, the Central Valley California HIDTA's Southern Tri-County Drug Task Force is a multi-agency initiative headquartered in Bakersfield, California that investigates all aspects of methamphetamine trafficking, including the acquisition of precursor chemicals, manufacturing, distribution, and money laundering. During 2003, the task force dismantled 17 superlabs, 12 precursor extraction laboratories, 12 "user" laboratories and processed 48 dumpsites. The investigators opened 248 new investigations during the year and disrupted or dismantled 15 drug trafficking organizations operating in the tri-county region. The investigations led to the arrest of 285 individuals on drug and other felony charges, and 64 drug-endangered children were rescued during the year.

The impact of the small toxic laboratories has been of particular note on a number of levels. First, small labs impact children growing up around, and ingesting, these chemicals. These labs contaminate the environment when methamphetamine cooks dump their toxic chemicals into the water table and onto farmland. Also, these labs create life-threatening hazards, such as explosion or chemical toxicity, which harms not only the people cooking methamphetamine, but first responders who try to save their lives by entering burning and contaminated sites. As noted above, the amount of methamphetamine consumed in the United States originating from these smaller clandestine laboratories is believed to be smaller than that originating from superlabs. However, due to the effects described above, they are a particularly pernicious problem.

**National Synthetic Drugs Action Plan**

Just last month, the Administration released the first-ever "National Synthetic Drugs Action Plan" (the Action Plan), which describes the Federal government's response to the production, trafficking and abuse of synthetic drugs like methamphetamine and MDMA, as well as the diversion of pharmaceutical products. Among the many recommendations of the Action Plan are those designed to cut off access to methamphetamine producers to precursors such as pseudoephedrine.
Federal legislation will be necessary to implement many of the recommendations set forth in the Action Plan. The new Synthetic Drugs Interagency Working Group, established by the Action Plan, will be developing recommendations to implement key provisions of the plan.

The Administration supports lowering the Federal limit on single-sales of pseudoephedrine products. The Action Plan's recommendations also include the deletion of the so-called "blister-pack exemption" that currently exists in Federal law. Though the exemption was initially implemented based on the expectation that methamphetamine manufacturers would not be likely to undergo the relatively difficult process of removing small amounts of pseudoephedrine from a large number of blister packs, law enforcement reports that even blister packs are being procured in large quantities and the emptied packs found at methamphetamine labs. For this reason, expecting blister-pack sales to abide by the same rules as other pill containers will help in the fight against methamphetamine production. Similarly, ensuring that these standards apply to the various forms of the product will prevent methamphetamine cooks from switching to alternate pseudoephedrine products, as the pills or tablets become more difficult to procure in significant quantities.

As with any regulatory scheme, it is critical that appropriate penalties be imposed for violation. Tough sanctions should be imposed upon not only methamphetamine producers and traffickers – both at the state and Federal level – but also upon those who illicitly traffic or distribute methamphetamine precursors such as pseudoephedrine. Especially because domestic superlabs have declined, and some of these superlabs appear to have been pushed to areas outside of our borders, a continuing focus by law enforcement on illicit shipments of bulk pseudoephedrine inside and outside our borders is critically important.

In response to the presence of these widespread smaller laboratories, the Action Plan highlights the importance of improved treatment, prevention, and education measures and makes several recommendations for Federal action in these areas.

Additional measures taken by some states have focused on limiting not only the amount of pseudoephedrine products that may be purchased, but also the location and manner in which the product may be purchased, and have imposed additional requirements for the process of the purchase itself. Over the next several months, the Administration will be closely analyzing the data and results in states where these innovative measures have been implemented. As many of these state actions were taken in the recent past,

the Administration will wait for better data and information to emerge before commenting on the effectiveness or impact of the various proposals to reduce methamphetamine availability or methamphetamine laboratory numbers and how they relate to Federal policy.

Critical to the successful implementation of the Action Plan's recommendations will be a continuing commitment to cooperation not only between Federal agencies, but also between the Executive and Legislative branches of the Federal government, and a continuing partnership with state and local entities committed to making the methamphetamine problem smaller.

**Conclusion**

Finally, it is important to remember that this drug threat, like others we have faced in the past, is not impervious to effective supply- and demand-control, as seen in Operation Northern Star. We know from years of experience that when we control the precursor chemicals and reduce the availability of methamphetamine, the price of the drug will rise. By prosecuting those who steal large quantities of pseudoephedrine from small mom-and-pop stores and those who would expose children to the toxic chemicals used to make this drug, we disrupt production. As we make treatment available, and support more people making it into recovery, demand will diminish. This requires all levels of government, as well as the private sector and our international allies, to commit to diminishing this threat to Americans' health and well-being.

Mr. SOUDER. Thank you very much.

Mr. Domingo Herraiz, who is the Director of the Bureau of Justice Assistance, Office of Justice Programs of the U.S. Department of Justice, arguably the most important agency to a lot of our local State and police agencies. We appreciate your coming today and look forward to your testimony.

Mr. HERRAIZ. Chairman Souder and members of the subcommittee, I am pleased to be here this morning before the subcommittee to discuss how the Office of Justice Programs provides support in addressing the problems of methamphetamine abuse, manufacturing, and tracking in the United States.

As requested by the committee, I will also discuss the Office of Community Oriented Policing Services, the COPS office, and their meth programs.

As we continue to combat the deadly scourge of methamphetamine, I want to point out that our overall effort in fighting crime is succeeding. I am pleased to report to you that the violent crime rate is the lowest in 30 years. For the first time in a decade we have seen teenage drug use fall across all boards, with the 8th, 10th, and 12th grade. Although we are encouraged by this data, if we want to continue the decline in crime, we realize we must remain committed to preventing crime and holding accountable those who violate our laws.

As BJA director, I now focus on the problems associated with meth from a national perspective. However, in my previous position as Director of the Ohio Office of Criminal Justice Services I saw firsthand the toll that meth has had on Ohio families and children, as well as the Ohio criminal justice system.

Mr. Chairman, as we both know coming from heartland States, the problems associated with meth production, distribution and abuse is of grave concern to rural areas.

Through various BJA funding sources, law enforcement agencies across the country are addressing the prevention and treatment of meth abuse, as well as the production, distribution, and exposure risks to officers and citizens. Meth task forces and other anti-drug efforts investigate and prosecute drug crimes, as well as work diligently to ensure law enforcement officers' safety while encountering meth labs. BJA also provides valuable training and technical assistance to law enforcement on task force management and investigation.

One of our primary funding sources for supporting efforts to fight meth abuse is the Edward Byrne Memorial State and Local Law Enforcement Assistance Program, which is a partnership among Federal, State, and local governments to create safer communities. Through Byrne, BJA awards grants to States for use by the States and units of local government to improve the functioning of the criminal justice system.

In fiscal year 2003 alone, at least eight States and partnering local communities made use of $2.76 million in Byrne Program funds for anti-meth efforts. For example, in Tennessee, Byrne funds were used to support both meth investigation and trafficking efforts, as well as prevention efforts. In Oregon, Byrne funds were used to support two different regional drug task forces for meth lab seizures, as well as the destruction of street-level distribution. A

Methamphetamine Response Team was funded in Kentucky and Kansas used Byrne funds to support the development of intensive supervision and treatment alternatives to meth abusers and offenders.

The Bureau of Justice Assistance, the Drug Enforcement Administration, and the Office for Community Oriented Policing Services prepared a program-level environmental assessment governing meth lab operations. Officers face unknown exposure, as you have already mentioned, when responding to homes, hotel rooms, vehicles, and other places where meth is being produced or consumed.

In addition, when the immediate exposure risks are mitigated, the problem isn't gone. Officers and departments must then decide what to do with the vehicle, the home, the hotel room that would normally soon be returned to its owners or occupants or used by other consumers, even though contamination may still be at unacceptable levels. Our assessment describes the adverse environmental, health, and safety impacts likely to be encountered by law enforcement agencies as they implement specific actions under their meth lab operations.

Another BJA source of support for these efforts to combat meth abuse is the Local Law Enforcement Block Grant Program, which provides funds to units of local government to underwrite projects that reduce crime and improve public safety. The LLEBG Program, as it is referenced, allows funds to be used for various types of meth responses, including establishing multi-jurisdictional task forces, paying for law enforcement overtime, and acquiring specialized equipment. The funds can also be used to cover or defray costs of insurance for hazardous assignments, as may be required with this issue.

In fiscal year 2004, LLEBG funds supported 12 projects in nine States, including Kentucky, Oregon, Texas, and Washington. For example, Richmond, Kentucky funded equipment purchases for a meth lab trailer that is used to process meth labs encountered within the county. Marion County, Oregon funded "NO METH: Not in My Neighborhood" program, and Washington County, also in Oregon, launched an Anti-Methamphetamine Education Campaign. Corpus Christi, Texas purchased meth response protective gear for its officers. Thurston County, Washington provided overtime for its officers to support anti-methamphetamine efforts within the county.

The administration has proposed replacing the Byrne and LLEBG Grant Programs with the new, more flexible Byrne Justice Assistance Grant Program in 2005. As you can see by these various funds, both the Law Enforcement Block Grant and the Byrne Program could be utilized for prevention, education, enforcement, and prosecution efforts.

The Drug Court Discretionary Grant Program is another BJA-administered program which is a valuable resource for communities experiencing methamphetamine problems. Drug courts can assist those who abuse meth and other drugs by providing treatment, drug testing, sanctions, and transitional services to offenders.

In addition to BJA's grant programs, I am placing an emphasis on providing training and technical assistance with regard to the complexities of the meth production and abuse. Just this past Octo-

ber, BJA, along with the Office of National Drug Control Policy and the Alliance for Model State Drug Laws, a BJA grantee, sponsored a National Methamphetamine Legislative and Policy Conference. The summit produced concrete strategies and raised awareness regarding additional work we need to do to comprehensively attack methamphetamine throughout the Nation.

Through the Center for Task Force Training, BJA provides training to law enforcement on basic investigation techniques and basic drug task force management issues such as personnel selection, handling confidential informants, and raid planning. After hearing from law enforcement about their need for additional training, we have more than tripled our number of methamphetamine training courses offered nationwide, for a total of up to 12 courses. These courses are offered at the State level, for the State themselves, to then bring in local law enforcement to provide them the opportunity to be trained. Most recently, we have scheduled a course, actually in Virginia, as the first pilot of this project.

Other components of the Office of Justice Program are also addressing meth use and serving its victims. For example, the National Institute of Justice is working on a comprehensive review of methamphetamine-related research that will identify lessons learned about enforcement and treatment, as well as research gaps that need to be addressed.

The Office for Victims of Crime has a bulletin available called "Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims." It explains that the best way to help these children is through coordinated multi-disciplinary efforts such as medical and mental health treatment services, child protective services, law enforcement, prosecution, and public safety officials.

As the subcommittee is aware, the Office of Community Oriented Policing Services [COPS], operates the COPS Methamphetamine Program. The program is intended to support State and local clandestine lab cleanup efforts. In 2005, the administration requests $20 million for that purpose.

Available on the COPS Web site is a problem-solving guide on clandestine drug labs and an evaluation of the COPS Meth Program. The guide is intended to help law enforcement develop proactive, prevention strategies and to improve the overall response to these incidents. The evaluation assesses the effectiveness of the community policing strategies employed by the various jurisdictions funded by the COPS Office under the Methamphetamine Program in fiscal year 1998. The evaluation report indicates successes among those agencies employing coordinated, proactive intervention tactics, including targeted enforcement strategies coupled with police and community awareness training regarding the production and distribution of the drug.

Even though these collective efforts from OJP and COPS are helping address the Nation's meth problem, we recognize we need to work harder with all of our State and local partners to ensure that resources are used effectively and efficiently. Through our conferences, we have learned from the field that they would be better served by having a centralized resource, a portal, if you will, for information on meth abuse and strategies, including law enforcement

and prosecution strategies, environmental briefs, research summaries, and funding information, and BJA is creating it.

We appreciate the interest that you and your colleagues have shown in this critical drug abuse issue. I welcome the opportunity to answer your questions as it relates to the Office of Justice Programs. I would request that any questions related to the COPS Program be submitted to the COPS office in writing. Thank you.

[The prepared statement of Mr. Herraiz follows:]

# Department of Justice

STATEMENT

OF

DOMINGO HERRAIZ
DIRECTOR
BUREAU OF JUSTICE ASSISTANCE
OFFICE OF JUSTICE PROGRAMS
U.S. DEPARTMENT OF JUSTICE

BEFORE THE

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

CONCERNING

LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE

PRESENTED ON

NOVEMBER 18, 2004

**Statement of**

**Domingo Herraiz**
**Director, Bureau of Justice Assistance**
**Office of Justice Programs**

**Before the**

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

**November 18, 2004**

***"Law Enforcement and the Fight Against Methamphetamine"***

Chairman Souder and Members of the Subcommittee: I am pleased to be here this morning on behalf of the U.S. Department of Justice (DOJ) Office of Justice Programs (OJP) before the Subcommittee to discuss how OJP provides financial and technical support in addressing the problem of methamphetamine abuse, manufacturing, and trafficking in the United States. As requested by the Subcommittee, my testimony also includes information on the Office of Community Oriented Policing Services (COPS) methamphetamine program.

As we continue to combat the deadly scourge of methamphetamine, we can take note that our efforts in fighting crime are succeeding. Thanks to the men and women of law enforcement, our achievements are impressive:

- We have driven the violent crime rate to its lowest level in 30 years.
- Over the past two years alone, we have dismantled 14 major drug-trafficking networks and seriously disrupted eight more.
- We have seen teenage drug use fall across the board for eighth-, tenth-, and twelfth-graders-the first time in a decade.

- Last month, a second survey showed that over the past two years, illegal drug use by 12- and 13-year-olds has dropped a stunning 29 percent for the gateway drug marijuana.

The data shows that these men and women continue to help make a difference in the prevention of drug abuse. We have taken more drug offenders off the street and have given those street corners back to the good people of the community. We are ensuring that hardened criminals do hard time in prison. And we remain committed to preventing crime and holding accountable those who violate our laws, including those who produce, traffic and abuse methampethamine.

As the Director of the Bureau of Justice Assistance (BJA), I focus on the problems associated with methamphetamine from a national perspective. However, in my previous position as Director of the Office of Criminal Justice Services in Ohio, I saw first-hand the toll that methamphetamine has on Ohio families and children, as well as the Ohio justice system. Mr. Chairman, as we both know, coming from heartland states, the problems associated with methamphetamine production, distribution, and abuse is of grave concern to rural areas. In fact, the Rural Indiana Profile reports that eighth graders in rural areas are 108 percent more likely to use methamphetamine than eighth graders in urban areas.

**BJA Programs Addressing Methamphetamine**

Through various BJA funding sources, law enforcement agencies across the nation are addressing the prevention and treatment of methamphetamine abuse, as well as the production, distribution, and exposure risks to officers and citizens. Methamphetamine task forces and other

anti-drug efforts investigate and prosecute drug crimes as well as ensure law enforcement officers' safety while encountering meth manufacturing areas. BJA also provides training and technical assistance through the Center for Task Force Training and the Regional Information Sharing System programs.

**The Edward Byrne Memorial State and Local Law Enforcement Assistance Program** is a partnership among federal, state, and local governments to create safer communities. BJA is authorized to award grants to states for use by states and units of local government to improve the functioning of the criminal justice system—with an emphasis on violent crime and serious offenders—and enforce state and local laws that establish offenses similar to those in the federal Controlled Substances Act. The Administration has proposed replacing this program with a new, more flexible Byrne Justice Assistance Grant Program in 2005.

Grants are primarily intended to seed promising practices and test new approaches to prevent and control crime, but may be used to provide personnel, equipment, training, technical assistance, and information systems for more widespread apprehension, prosecution, adjudication, detention, and rehabilitation of offenders who violate state and local laws. Grants also may be used to provide assistance (other than compensation) to the victims of these offenders.

In fiscal year 2003 alone, at least eight states and partnering local communities made use of $2.76 million in Byrne Program funds for anti-methamphetamine efforts. For example, in

Tennessee, Byrne funds were used to support methamphetamine investigation tracking efforts as well as prevention efforts tied in with code enforcement strategies and strategies related to monitoring of precursor chemicals. In Oregon, Byrne funds were used to support two different regional drug task forces for meth lab seizures as well as disruption of street-level distribution. A Methamphetamine Response Team was funded in Kentucky, and Kansas used Byrne funding to support the development of intensive supervision and treatment alternatives for meth abusers/offenders. Iowa and Colorado both used Byrne funding to support prevention efforts. Iowa's services targeted drug-endangered children while Colorado used Byrne funds to provide training for first responders as well as building inspectors and others likely to come into contact with methamphetamine and/or its precursor chemicals.

Because of the hazards associated with chemicals involved in the production of methamphetamine, BJA works with Byrne grantees to ensure compliance with the National Environmental Policy Act. The risks to people exposed to these chemicals are significant and far-reaching. In fact, states receiving Byrne funds and subgrantees under the Byrne Program may not use their grant monies for the identification, seizure, or closure of methamphetamine labs unless they are in compliance with certain grant conditions.

OJP, in coordination with BJA, the Drug Enforcement Administration, and the Office for Community Oriented Policing Services, prepared a program-level environmental assessment governing meth lab operations. The assessment describes the adverse environmental, health, and safety impacts likely to be encountered by law enforcement agencies as they implement specific

actions under their meth lab operations. There are several conditions that apply to grantees for any OJP-funded meth lab operations:

- Grantees must ensure compliance by OJP-funded subgrantees with federal, state, and local environmental, health, and safety laws and regulations applicable to meth lab operations, including the disposal of the chemicals, equipment, and wastes resulting from those operations.
- Grantees must have a mitigation plan in place that identifies and documents the processes and points of accountability within its state.
- Grantees must monitor OJP-funded meth lab operations to ensure that they comply with the nine mitigation measures identified in the assessment.

Unfortunately, officers also face unknown exposure when responding to homes, hotel rooms, vehicles, and other places where methamphetamine is being produced or consumed. In addition, when the immediate exposure risks are mitigated, the problem isn't gone. Officers and departments must then decide what to do with a vehicle, home, or hotel room that would normally be soon returned to its owners/occupants or used by other consumers, even though contamination may still be at unacceptable levels. It is inconceivable to me how this can happen to our communities, and the level of risk to law enforcement is intolerable.

**The Local Law Enforcement Block Grant (LLEBG) Program** provides funds to units of local government to underwrite projects that reduce crime and improve public safety based on a formula derived from Part I violent crime rates. The LLEBG Program emphasizes local decision-making and encourages communities to craft their own responses to local crime and drug problems. The Administration has proposed consolidating this program, along with the Byrne Memorial Grants, into a new, more flexible Byrne Justice Assistance Grant Program in 2005.

The LLEBG program guidelines allow funds to be used for various types of methamphetamine responses, including establishing multijurisdictional task forces, paying for law enforcement overtime, and acquiring specialized equipment. The funds can also be used to cover or defray the cost of insurance for hazardous assignments, as may be required with this issue.

In FY 2004, LLEBG funds supported 12 projects in 9 states, including Kentucky, Oregon, Texas, and Washington. Richmond, Kentucky funded equipment purchases for a methamphetamine laboratory trailer that is used to process meth labs encountered within the county. Oregon funded two education programs: Marion County funded "NO METH: Not in My Neighborhood," and Washington County launched an Anti-Methamphetamine Education Campaign. Corpus Christi, Texas purchased methamphetamine response protective gear for its officers. Thurston County, Washington provided overtime for its officers to support anti-methamphetamine efforts within the county.

**The Drug Court Discretionary Grant Program** is another valuable resource for communities experiencing methamphetamine problems. This program provides financial and technical assistance to states, state courts, local courts, units of local government, and Indian tribal governments to develop and implement drug courts that effectively integrate substance abuse treatment, mandatory drug testing, sanctions and incentives, and transitional services in a judicially supervised court setting with jurisdiction over nonviolent, substance-abusing

offenders. Drug courts assist those who abuse meth and other drugs by providing treatment, drug testing, sanctions, and transitional services to offenders.

There are currently over 1,500 operating drug courts in the United States, and many jurisdictions are interested in implementing new drug courts. In addition to funding drug court planning, implementation, and enhancement in FY 2005, BJA expects to train over 200 teams from communities across the U.S. in the drug court program, which underscores the field's strong desire for additional drug courts and improved drug court capacity, which will provide additional response options for communities dealing with methamphetamine problems.

In addition to BJA's grant programs, an emphasis has been placed on providing training and technical assistance with regard to the complexities of methamphetamine production and abuse. Just this past October, BJA, along with the Office of National Drug Control Policy (ONDCP) and the Alliance for Model State Drug Laws (a BJA grantee), sponsored a National Methamphetamine Legislative and Policy Conference. Participants from law enforcement, public health, treatment organizations, and other units of local government and justice system personnel from around the U.S. discussed ways to better address the methamphetamine problem through local ordinances and state statutes. The work at the summit produced concrete strategies and raised awareness regarding additional work needed to comprehensively attack methamphetamine throughout the nation.

BJA supports the Center for Task Force Training (CenTF), which provides training to law enforcement on task force management, investigation, and rave/club drug investigation and

response. The Narcotics Task Force Management Course and the Methamphetamine Task Force Management Course both address basic investigation techniques and basic task force management issues such as personnel selection, handling confidential informants, raid planning, and related issues. The Methamphetamine Task Force Management Course, delivered through two days of instruction, also provides investigators and managers with information on methamphetamine and its precursor chemicals, exposure risks, and suggestions on handling meth lab seizures.

In FYs 2004/2005, after hearing from law enforcement of their need for additional training, we have more than tripled the number of methamphetamine training courses offered nationwide, for a total of up to 12 courses. These courses will be delivered in addition to three Narcotics Task Force Management Courses.

As you may know, in each State the Governor identifies an agency to administer the Byrne Program funds. Their agency is the State Administering Agency (SAAs). Our strategy for delivering these trainings calls for BJA and CenTF to partner with the SAAs to ensure that the training reaches the most needed areas, agencies, and officers. An SAA in each of BJA's five administrative regions will be chosen to host the course for that region. The first such training will occur in the Commonwealth of Virginia. BJA identified Virginia after learning that it is planning a statewide methamphetamine summit to address its growing meth problem. By hosting the training through the SAA and in conjunction with the summit, we will demonstrate a strong partnership between local communities, state justice organizations, and the federal government.

BJA supports the Regional Information Sharing System (RISS), which aids law enforcement in the investigation of methamphetamine operations. It provides secure communication capabilities and other support such as investigative analysis products, specialized surveillance equipment loans, and confidential funds for undercover operations. The RISS Program is comprised of six regional centers that serve member agencies in their areas. As a part of the secure communications network, officers accessing the RISSnet secure communications network can also access the intelligence and other database services of local, state, and federal agencies, several High Intensity Drug Trafficking Areas (HIDTAs), a national gang intelligence database (RISSGang), the National Drug Intelligence Center, as many as 23 state justice systems, and the National Virtual Pointer Index System (NVPS), which is a narcotics investigation deconfliction system.

In 2003, the RISS Program provided approximately $188,000 in confidential funds for the purpose of investigative information, contraband, stolen property, and other evidentiary items and made over 4,720 loans of specialized surveillance and investigative equipment. Resources such as this are critical, particularly for small law enforcement agencies that lack the financial resources to provide them on their own. As a result of these services, member agency investigations supported by RISS Center services resulted in over 4,600 arrests, the seizure of $67 million in narcotics, $13 million in property, and $4 million in currency seized or recovered.

**Other OJP Efforts Addressing Methamphetamine Abuse**

Our National Institute of Justice (NIJ) is working on a comprehensive review of methamphetamine-related research. Drafting of a report (due to be released in early 2005) is underway that will identify lessons learned about enforcement and treatment and will identify research gaps that need to be addressed. The report will include:

- An extensive timeline documenting the history and evolution of methamphetamine abuse in the U.S.;
- Information about methamphetamine chemical makeup, including recipes, precursor chemicals, and retail products needed for methamphetamine creation;
- An historical overview of federal, state, and local law enforcement efforts to combat methamphetamine production and abuse;
- A review of current treatment practices for methamphetamine users; and
- A discussion of the lack of adequate information on methamphetamines in the most widely used data systems designed to combat drug abuse.

In 2003, our Office for Victims of Crime (OVC) released a bulletin focusing on victims of methamphetamine use who are too often overlooked – children found living or visiting methamphetamine laboratories. These children face severe health and safety risks, including fires and explosions. Increasingly, child protection workers found that these children suffer from burns, bruises, untreated skin disorders, bites, and infections. These children are often abused both physically and emotionally, and their needs are frequently neglected. They are also exposed to an unhealthy atmosphere, including the presence of firearms and parents engaged in criminal behavior.

The bulletin, *Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims*, explains that the best way to help these children is through coordinated multi-disciplinary efforts, such as, medical/mental health services, child protective services, law enforcement, prosecutors, and public safety officials. It is available through the OVC website at www.ojp.usdoj.gov/ovc.

**COPS Methamphetamine Program**

The Office of Community Oriented Policing Services – also known as COPS – operates the COPS Methamphetamine Program. The program is intended to support state and local clandestine lab clean-up efforts. In 2005, the Administration requests $20 million for this purpose.

Available on the COPS website at www.cops.usdoj.gov is a problem-solving guide on clandestine drug labs and an evaluation of the COPS Meth Program. The guide is intended to help law enforcement develop proactive, prevention strategies and to improve the overall response to these incidents. The evaluation assesses the effectiveness of the community policing strategies employed by the various jurisdictions funded by the COPS Office under the Methamphetamine Program in FY 1998. The evaluation report indicates success among those agencies employing coordinated proactive intervention tactics, including targeted enforcement strategies coupled with police and community awareness training regarding the production and distribution of the drug.

**Conclusion**

Even though these collective resources from OJP and COPS are helping address the nation's methamphetamine problem, we strive to work harder with all of our partnering agencies to ensure that resources are used effectively and efficiently at the federal and local levels. Further, through our conferences, we have learned from the field that they would be better served by having a centralized resource—or pointer system—for information on methamphetamine abuse and strategies to address the problem, including law enforcement and prosecution strategies, environmental briefs, research summaries, funding information, and related topics. We plan to work with our federal partners and outside organizations in pursuing the idea of an online meth resource center. We want to explore every feasible option that will have a strong impact on making methamphetamine abuse a trend of the past.

We appreciate the interest you and your colleagues have shown in this critical drug abuse issue. I welcome the opportunity to answer any questions that you may have.

Mr. SOUDER. Thank you.

Our next witness is Mr. Joseph Rannazzisi. I appreciate your work as the Deputy Chief of the Office of Enforcement of DEA. DEA increasingly plays not only an internationally important role, but in the United States working with our local drug task forces. So I am glad you came to testify today and look forward to your testimony.

Mr. RANNAZZISI. Thank you very much, sir. Chairman Souder, Ranking Member Cummings, distinguished members of the subcommittee, and fellow panel members, on behalf of Administrator Karen Tandy, I appreciate your invitation to testify today on the importance of law enforcement's fight against methamphetamine.

Until the late 1980's, methamphetamine's popularity was primarily confined to the west coast and southwest. By the early 1990's, methamphetamine was gaining in popularity, spreading west to east across the country, and hitting rural areas particularly hard. No community is immune.

There are three distinct components to combating the overall methamphetamine problem: first, enforcement; second, a comprehensive domestic and international precursor control program; and, third, the identification and cleanup of the growing number of small toxic labs, which we call STLs.

As a result of our efforts and those of our law enforcement partners across the country and in Canada, since 2001, the United States has seen a 79 percent decrease in the seizure of superlabs. Enforcement efforts have also led to an 85 percent reduction in the amount of pseudoephedrine, ephedrine, and other methamphetamine precursors seized at the Canadian border, and the price of black market pseudoephedrine in California has doubled.

Internationally, the DEA is working with our foreign counterparts to prevent the diversion of pseudoephedrine from Europe, China, and India to methamphetamine producing countries.

Specialized training is required to safely and effectively conduct these investigations, and our Office of Training has developed a program for our agents, State and local officers, and our foreign counterparts. Since fiscal year 2000, we have provided basic clandestine laboratory training certification to over 6100 State and local law enforcement officers. Additionally, we are providing clandestine lab awareness training to approximately 17,000 students per year.

Heightened enforcement efforts have resulted in a dramatic increase throughout the country. To properly dispose of resulting waste, the DEA has enlisted the services of the private sector to help clean up these lab sites. The DEA's Hazardous Waste Program, with the assistance of the COPS Program, supports and funds the cleanup of the majority of the laboratories seized in the United States. Though the number of cleanups has increased more than 4,000 percent, the average cost per cleanup has continued to decrease.

In addition to the drain on law enforcement resources, the demands on medical, social, environmental, and public health and safety services continue to grow. STLs account for the vast majority of clandestine labs and are often discovered in areas where children live and play. These STLs also generate toxic waste, which is

frequently discharged on the ground, into the waterways, or down the drain. Clearly, given the problem of this magnitude, there is a need for new approaches and strong regulatory controls on precursor chemicals used to manufacture methamphetamine.

The regulation of ephedrine and pseudoephedrine is a vital overall strategy to combat methamphetamine abuse. State legislative measures have focused on limiting the amount of pseudoephedrine products that may be purchased, the location and manner in which the product may be purchased, the requirements for the process and purchase itself. Because State action regulating methamphetamine precursors is a recent development, the administration will wait for better data and information to emerge before commenting on the effectiveness and impact of any particular action in reducing methamphetamine availability or methamphetamine laboratory numbers and how they relate to Federal policy.

The administration recently released the National Synthetic Drug Action Plan. In doing so, the Department of Justice, ONDCP, and DEA proclaimed the seriousness of the challenges posed by methamphetamine, along with other synthetic drugs and diverted pharmaceuticals, as well as our resolve to confront these challenges. The Action Plan outlines specific steps the Federal Government will take to accelerate our national efforts against these harmful substances.

The DEA is energetically combating our national methamphetamine epidemic on several fronts: we are engaged in aggressive enforcement, comprehensive domestic and international precursor chemical control, the identification of cleanup of the growing number of STLs, and providing clandestine laboratory training to our law enforcement partners, as well as our foreign counterparts. In addition to our efforts in these areas, we also believe that stricter regulatory controls of precursor chemicals is one of the most effective tools available to assist in the fight against illicit methamphetamine production.

Thank you for your recognition of this important issue and the opportunity to testify here today. I look forward to answering any questions you may have. Thank you.

[The prepared statement of Mr. Rannazzisi follows:]

**Statement of**

**Joseph T. Rannazzisi**
**Deputy Chief of the Office of Enforcement**
**Drug Enforcement Administration**

**Before the**

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

**November 18, 2004**

**"Law Enforcement and the Fight Against Methamphetamine"**

Chairman Souder, and distinguished members of the House Government Reform Committee, Subcommittee on Criminal Justice, Drug Policy and Human Resources, on behalf of Administrator Karen Tandy, I appreciate your invitation to testify today on the importance of law enforcement's fight against methamphetamine.

***Overview***

Until the late 1980's, methamphetamine's popularity was primarily confined to the West Coast and the Southwest. By the early 1990's, methamphetamine was gaining in popularity, spreading west to east across the country, and hitting rural areas particularly hard. At present, the United States is experiencing an unprecedented rise in the use, trafficking, and manufacturing of methamphetamine. The wholesale abuse of the drug itself is serious enough. But when we factor in the toxic environmental effects from unregulated chemicals used in clandestine laboratories, we see that methamphetamine is taking a terrible toll. No community is immune.

In an effort to address the social ramifications associated with this growing menace, the Drug Enforcement Administration (DEA) aggressively targets those who traffic in and produce this dangerous drug, as well as those who traffic in the chemicals utilized to manufacture methamphetamine. We have initiated and led successful enforcement efforts focusing on methamphetamine and precursor chemicals and have worked jointly with our federal, state and local law enforcement partners. The efforts of law enforcement have resulted in major successful investigations, which have dismantled and disrupted high-level methamphetamine trafficking organizations, as well as dramatically reduced the amount of pseudoephedrine entering our country, particularly along the Northern Border.

Unable to accomplish this task alone, the DEA shares its expertise by training thousands of law enforcement officers from all the over country. Law Enforcement

personnel gain the necessary expertise and are provided equipment needed to safely and properly deal with clandestine laboratories from our DEA training programs. Meanwhile, we closely monitor state legislation that addresses methamphetamine and pseudoephedrine.

***Battling Methamphetamine***

There are three distinct components to combating the overall methamphetamine problem: first, enforcement; second, comprehensive domestic and international precursor chemical control; and third, the identification and cleanup of the growing number of small toxic laboratories (STL's).

As a result of our efforts and those of our law enforcement partners in the U.S. and Canada, we have seen a dramatic decline in methamphetamine "super labs" in our country. Since 2001, the number of super labs seized in the U.S. has dropped 79 percent. Enforcement efforts have also led to an 85 percent reduction in the amount of pseudoephedrine, ephedrine and other methamphetamine precursors seized at the Canadian border, and the price of black market pseudoephedrine in California has doubled. In the past seven years, more than 2,000 chemical registrants have been denied, surrendered, or have withdrawn their registrations or applications as a result of DEA investigations. Between 2001 and 2003, DEA Diversion Investigators physically inspected almost half of the 3,000 chemical registrants at their places of business, investigating the adequacy of their security safeguards to prevent the diversion of chemicals to the illicit market, and auditing their recordkeeping to ensure compliance with federal regulations.

Internationally, the DEA is working with our foreign counterparts to prevent the diversion of pseudoephedrine from Europe, China and India to methamphetamine producing countries. We have DEA Task Forces nationwide, as well as specialized teams of DEA Agents, who investigate clandestine laboratory operators. These types of investigations require specialized training, which our Special Agents and thousands of state and local officers have received at DEA's training academy in Quantico, Virginia.

The DEA spends an estimated $145 million annually to combat methamphetamine. This includes an estimated $119 million on enforcement, tracking chemicals and investigating illegal shipments of pseudoephedrine, ephedrine and other precursors used to manufacture methamphetamine. It also includes approximately $4 million in DEA funds for clan lab cleanup, and almost $2 million for lab cleanup equipment. In addition, DEA manages $20 million from the Community Oriented Police Services (COPS) program which is dispersed for state and local clan lab cleanup.

***DEA's Clandestine Laboratory Training***

As the number of nationwide clandestine laboratory seizures continues to mount into the thousands, there has been a corresponding demand for related training from state

and local law enforcement organizations. Since 1998, with funding received originally through the COPS program and then through direct appropriations to the annual budget, the DEA has offered a robust training program for state and local officers. The DEA provides basic and advanced clandestine laboratory safety training for state and local law enforcement officers and Special Agents at the DEA Clandestine Laboratory Training Facility. Established instruction includes the Basic Clandestine Laboratory Certification School, the Advanced Site Safety School, and the Clandestine Laboratory Tactical School.

Each course exceeds Occupational Safety Health Administration (OSHA)-mandated minimum safety requirements, lasting approximately one week, and is provided at no cost to qualified state and local law enforcement officers. The specialized Clandestine Laboratory Training Unit also provides in-service training and seminars for law enforcement groups such as the Clandestine Laboratory Investigator's Association and the International Association of Chief's of Police. The Unit also conducts a number of courses off-site each year to meet regional training demands and provides annual recertification training as required by OSHA.

Since FY 2000, the DEA's Office of Training has conducted numerous clandestine laboratory schools and has provided basic training/certification to over 6,100 state and local law enforcement officers from across the country. Additionally since 1999, the DEA has provided clandestine laboratory awareness training to approximately 17,000 students per year. The Office of Training also provides clandestine laboratory awareness and "train the trainer" programs that can be tailored for a specific agency's needs, with classes ranging in length from one to eight hours. DEA training is pivotal to ensuring safe and efficient cleanup of methamphetamine lab hazardous waste.

In addition to training our own agents and state/local counterparts in the United States, we also train our counterparts in other countries regarding precursor chemical control, investigation and prosecution. In particular, we have provided training regarding the investigation and prosecution of precursor chemical diversion to our Mexican counterparts on five occasions since June of 2003. This training was provided to over 100 officials who regulate precursor chemicals and pharmaceuticals at the state and federal level within Mexico, as well as agents from the Agencia Federal de Investigaciones (AFI) and several prosecutors within the Mexican Organized Crime Unit (SIEDO).

***Hazardous Waste Cleanup***

The DEA has heightened its enforcement efforts concerning methamphetamine trafficking in recent years. State and local agencies have also witnessed an increase in the number of organizations operating illicit methamphetamine laboratories in their jurisdictions. This has resulted in a dramatic increase in the number of clandestine laboratories seized throughout the United States. When a federal, state or local agency seizes a clandestine methamphetamine laboratory, Environmental Protection Agency

regulations require that the agency ensure that all hazardous waste materials are safely removed from the site.

In 1990, the DEA established a Hazardous Waste Cleanup Program to address environmental concerns from the seizure of clandestine drug laboratories. We enlisted the services of the private sector to aid in environmentally sound clandestine drug laboratory cleanup. Private contractors provide hazardous waste removal and disposal services to the DEA, as well as to state and local law enforcement agencies. This program promotes the safety of law enforcement personnel and the public by using qualified companies with specialized training and equipment to remove hazardous waste generated by these clandestine labs.

The DEA's hazardous waste program, with the assistance of the COPS program, supports and funds the cleanup of a majority of the laboratories seized in the United States. Between 1992 and 2004, the number of clandestine lab related cleanups increased from 394 to nearly 17,000. Even though the number of cleanups has increased by over 4,000 percent, the average cost per cleanup has continued to decrease since the DEA first began using contractor services in the early 1990's. Currently, the average cost per cleanup is $1,900, down from $3,300 in FY 2002. In a continuing effort to reduce the costs of lab cleanups, the DEA initiated the Clandestine Lab Container Program. This pilot program, in conjunction with the state of Kentucky, reduced law enforcement overtime costs and hazardous material cleanup by streamlining the process. The average cost of cleanup in this project is $320.

***Methamphetamine's Innocent Victims***

In addition to the evident drain on law enforcement resources, the demands on medical, social, environmental, and public heath and safety services continue to grow. This is particularly true when it comes to the health and safety of children exposed to the toxic chemicals used in the manufacture of this illegal substance. STL's account for the vast majority of clandestine labs seized and are often discovered in vehicles, buildings, and homes. Many of these lab sites are also locations where children live and play. According to the El Paso Intelligence Center (EPIC) over 3,000 children were present during the seizure of clandestine laboratories nationwide in 2003.

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. In response to these tragic phenomena, the DEA has enhanced its Victim Witness Program to identify, refer and report these incidents to the proper state agencies. Each of the DEA's Field Divisions has a Victim/Witness Coordinator to ensure that all endangered children are reported. This DEA program guarantees that endangered children are identified and that the child's immediate safety is addressed at the scene through coordination with child welfare and health care service providers.

Small but dangerous methamphetamine laboratories pose threats not only to our citizens, but to the environment as illicit lab operators discharge their toxic waste on the ground, into waterways or down the drain. Last year, there were approximately 17,000 clandestine laboratory related incidents (including seizures of laboratories and dumpsites) reported to EPIC by U.S. law enforcement agencies. Clearly, given a problem of this magnitude, there is a need for new approaches and stronger regulatory controls on precursor chemicals used to manufacture methamphetamine.

***New Approaches: The National Synthetic Drugs Action Plan***

In late October of this year, the Administration released the National Synthetic Drugs Action Plan. In doing so, the Department of Justice, the DEA and ONDCP proclaimed the seriousness of the challenges posed by methamphetamine - along with other synthetic drugs and diverted pharmaceuticals - as well as our resolve to confront those challenges. The Action Plan outlines specific steps the federal government will take to accelerate our national efforts against these harmful substances. Many of the recommendations in this Action Plan represent cutting edge approaches. For example, we will refine an "early warning" system to detect and respond to new drug threats, the "next methamphetamine," before it builds into a larger drug threat.

Many of the most forward-looking recommendations in the Action Plan relate to regulatory initiatives to control precursor chemicals that are diverted to the illicit production of methamphetamine. This includes removal of the so-called "blister pack" exemption from regulatory controls by appropriate legislation. This exemption has proven to be a loophole exploited by clandestine lab "cooks." The plan also supports legislation to enable imposition of import controls on bulk ephedrine and pseudoephedrine that would limit imports to the quantity needed to support legitimate commercial needs. This is similar to the quota system for Schedule I and II controlled substances that is currently in place. An adjunct to this authority would be new tools to regulate the after-import chemical "spot market" by which some firms are able to sidestep chemical controls currently in place.

We cannot address methamphetamine without the assistance of our international counterparts. The Action Plan recognizes the need to strengthen our cooperation with Mexico by (1) increasing the effectiveness of bilateral chemical control efforts, and (2) providing training and technical assistance to our Mexican law enforcement colleagues, so that they can detect and safely seize and dismantle the methamphetamine labs that are now beginning to proliferate in that country. Mexico is showing welcome initiative in addressing the critical aspects of this problem: chemical control, criminal investigations, and lab seizures and cleanup.

The Action Plan also suggests strengthening the worldwide chemical control system to make chemical controls more formal and universal. Methamphetamine is made from diverted chemicals, and chemical commerce is highly international.

The DEA and our colleagues at the Department of Justice and throughout the Administration are committed to the Action Plan. We will participate actively in our assigned interagency working groups to implement the recommendations in the plan. The Action Plan is a promising roadmap, but continuing adjustments in priorities and approaches will inevitably be needed to respond to changes and challenges that we face.

***Regulating Methamphetamine's Precursor Chemicals***

The regulation of ephedrine and pseudoephedrine is a vital part of the overall strategy to combat the spread of methamphetamine abuse. Ephedrine and pseudoephedrine are the primary ingredients necessary to make methamphetamine. These chemicals are commonly available as single entity or combination over-the-counter (OTC) products. As a consequence of the proliferation of small toxic labs across the country, federal, state and local legislators have moved to limit easy access to these products

The type of these restrictions varies from one jurisdiction to another. The most common form of restriction limits the amount of pseudoephedrine that can be purchased at one time. This varies from 3 to 9 grams of pseudoephedrine per purchase. Current federal law restricts the purchase to 9 grams per transaction unless sold in blister packs, which are protected by the "safe harbor" provision of the Controlled Substances Act. A number of states have regulated the manner in which pseudoephedrine products are sold. Many states have enacted laws which make it a crime to possess pseudoephedrine with intent to manufacture methamphetamine.

State measures have focused on limiting the amount of pseudoephedrine products that may be purchased; the location and manner in which the product may be purchased; and requirements for the process of the purchase itself. Because state action regulating methamphetamine precursor chemicals is a recent development, the Administration will wait for better data and information to emerge before commenting on the effectiveness and impact of any particular action in reducing methamphetamine availability or methamphetamine laboratory numbers and how they relate to Federal policy.

As part of the National Synthetic Drugs Action Plan we will work with other agencies over the next several months to closely analyze the data and results in states where these new measures have been implemented. The Plan also calls for a Synthetic Drugs Interagency Working Group. As part of this group, the DEA will measure the effects of these state efforts in order to assist in the formulation of the most effective federal policy to curb further proliferation of methamphetamine production.

***Conclusion***

The DEA is energetically combating our national methamphetamine epidemic on several fronts. We are working closely with state and local law enforcement to eliminate the spread of small toxic labs. Our efforts also include preventing diversion and targeting

the traffickers of precursor chemicals on a domestic and international level, as well as providing training and assistance to state and local law enforcement officers throughout the United States.

Mr. Chairman, the DEA will continue to devote its resources to identify, investigate, and dismantle the organizations responsible for the spread of methamphetamine across our country. Control of precursor chemicals is one of the most effective tools in the fight against illicit methamphetamine production. Stricter regulatory controls would support our enforcement efforts and assist in reducing the number of small toxic laboratories.

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

Mr. SOUDER. Thank you.

I want the record to show, too, that what our committee is finding is that the national EPIC number of 17,000 is tremendously understated. In northeast Indiana alone, in talking with our sheriffs, the number in my district exceeds the number for the State; and in Northwest Arkansas, they had more than was reported for their entire State; and in meetings that we had with Congressman Alexander in Alexandria and Monroe, Louisiana, with about 30 to 50 sheriffs and prosecutors, they just dwarfed the numbers that are reported.

It doesn't appear that any one State is off; it is a process. But I think that explains some of the political pressure that we are hearing, because somehow our numbers aren't matching in the reporting, and I think it is just a lot of them are very small local police that are so overwhelmed.

In my district we can't build enough jails to put the meth addicts in. Every single county outside of Allen County, where Fort Wayne is, has the majority of their jail spots filled right now with meth addicts. And the second they let them out, they are right back in it. They are the most immune group to treatment that we have faced in any of our drug questions right now, and it is partly why we are feeling this political pressure.

But first I wanted to ask Mr. Burns and Mr. Rannazzisi, on the small meth labs, what is the main source of precursor supply? Do you feel they are buying it from pharmacies or stealing it? Do they get the anhydrous ammonia and other solvents by buying them or stealing them?

Mr. RANNAZZISI. Let us talk about the anhydrous ammonia first. Extremely dangerous chemical used in farming. A necessary tool for farmers. Basically, they are stealing it. They are walking in, looking at nurse tanks that are on farmland, waiting late at night, walking onto the farmland, tapping into the nurse tank, an extremely dangerous situation. Anhydrous ammonia is a terrible, terrible chemical as far as inhalation; severe medical damage to the lungs. There have been countless reports of police officers and people being injured or killed, citizens being killed because of anhydrous.

If you remember correctly, I believe it was last year there was a meth lab operator who tapped into a high-pressure anhydrous line in Florida. It was a pipeline. It scorched 500 acres of land. I believe two residential developments were evacuated and a school. Obviously, they need the chemicals, and they go after the chemical that way.

Mr. SOUDER. What about the pseudoephedrine?

Mr. RANNAZZISI. Pseudoephedrine is available in all different markets. I believe we have done a very good job in stopping the bulk flow across the Canadian border. We do know that pseudoephedrine is still sent out from, as you said, the European countries and China and India. There is that sector of bulk pseudoephedrine; there is also the retail sector. Obviously, you could walk into pharmacies and buy pseudoephedrine.

Mr. SOUDER. There is no reason to steal it if you can buy it over the counter.

Mr. RANNAZZISI. Right. There are reports where people have done sweeps where they have actually walked into pharmacies with shopping bags and just swept the whole shelf, put them in the bag and ran out of the store. There are serious concerns about stealing as well. The profit margin is so high, though, if you think about it, why would you want to steal it and get caught, when you could purchase it. You could smurf it, go to five, six, seven pharmacies or other areas, purchase it, and make your methamphetamine.

Mr. SOUDER. Because a lot of the mom-and-pop people are cooking for themselves, or maybe two people, and they can buy it. It is only if they maybe start to get a circle of 10 to 15 would you start to see——

Mr. RANNAZZISI. I believe that is accurate. Well, I don't like to call them mom-and-pop labs; we call them STLs. As a gentleman in Kentucky told me, I've known my mom and pop for 43 years, and I have never gone home and watched them cook meth. And I really believe that is accurate. We call them STLs because that is what they are, they are very toxic labs.

Mr. SOUDER. But there is a difference between those who are predominantly cooking for themselves and the immediate household, and those who are actually dealers as well.

Mr. RANNAZZISI. That is right. If you look at the people who are cooking in their houses, you are looking at small labs, probably no more than an ounce. Then you have the people who are cooking to support their habit and also to make money. They are going to be the multi-ounce purchasers. They are the guys who are going to be going out and smurfing large quantities of retail sales pseudo, and they are going to be going to 5, 6, 7, 10 retail distributors purchasing their packs, bringing it home and starting the process.

Mr. SOUDER. Oklahoma has probably the toughest law at this point, and they seem to be making some progress. Do you believe that is because of the law?

Mr. RANNAZZISI. I am very cautious to discuss the Oklahoma law, and the reason is because, as you said, the statistics that are coming out now—let us talk about the CLSS first of all. I think you mentioned that the CLSS statistics are kind of off; and the reason is that there is always a time lag between when the lab is seized and when the paperwork is submitted.

Now, on the CLSS, paperwork is submitted from all different areas. On the west coast it is submitted through WISEN, which is a collaborative intelligence center; there could be a 2 to 3-month lag time. But in these smaller departments, they have so much to do, they might not submit their paperwork for 3, 4, or 5 months. They are getting it in, they just are not getting it in on a timely basis.

And I understand, I was a lab agent for many years; I still am a lab agent. I don't feel that blame should be put on those officers; they are doing their best. But that is why we don't look at those statistics. We don't look at the November statistics and say, look at this, this is where we are. We usually wait about 4 to 6 months from the month we are looking at to make a determination that is a good number.

So what I would like to do, and I think what the administration and the Department wants to do, is sit back and wait about a year.

Look at the statistics after a year to make a determination how much impact that Oklahoma legislation had. I think that is the prudent thing to do.

Mr. SOUDER. Did you see the Oregonian, which has a cumulative chart that combines DEA data and a Rand Study that shows when we regulated ephedrine, the purity of meth dropped dramatically over a period of a number of years? Then as they figured out they could use pseudoephedrine, it went back up again. And when we started to put more regulations on pseudoephedrine, it dropped again. That is a long-term chart that shows some correlation to the regulation that uses some DEA data. Are you familiar with that chart?

Mr. RANNAZZISI. I have read that article numerous times and I am familiar with that. I am interested to see where the purity data came from. I am not familiar with the sources that they got that data from. Obviously, whenever we have a major enforcement push, an operation that cuts the flow of precursor chemicals, there is going to be less of a market, less methamphetamine on the market. If there is less methamphetamine on the market, the dealers that have the methamphetamine are going to cut their product to service more people, so you are going to see a period of decrease. That is an absolute.

Mr. SOUDER. I would appreciate it if you could, since the footnote source is DEA and a Rand Study, get back to us with particulars. Because if that study is incorrect—I know the difficulty of determining purity, too. A chart makes it look very scientific, but that is actually good news, if we show that when we combine intercept internationally and control at the local pharmacy level, that we have a reduction in purity. But I would like to make sure that chart is accurate.

Mr. RANNAZZISI. Thank you, sir. I will take care of that.

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. You don't believe that the numbers are accurate when it comes to people involved in using methamphetamine? It sounds like you and the chairman were in some agreement on that. In other words, the number of people, whether the stats that we get—he just talked about Indiana, and then you seem like you kind of verified it, that you don't believe that the stats. He said the jails are filled with methamphetamine addicts, and I thought you kind of verified it, but tell me.

I guess what I am trying to get to is, first of all, we have to understand what our problem is and the extent of it, before we can deal with it; and if we are not getting numbers that are accurate—and you gave some reasons why they might not be accurate, but, first of all, I want to know you obviously believe that the problem is worse than what it appears to be, or what the information is being put out to be.

Mr. RANNAZZISI. Oh, absolutely. I believe there is a terrible problem with methamphetamine abuse, and I believe there is a very large population of abusers out there. I believe there is a large population of abusers that haven't been identified. That is absolutely correct.

Mr. CUMMINGS. I listened to you talk about things that the DEA was doing—and, gentlemen, you might want to chime in whenever you get ready to—and we are talking about training?

Mr. RANNAZZISI. Yes, sir.

Mr. CUMMINGS. Tell me just generally about the training. What does the training entail that is different than, say, dealing with other drugs?

Mr. RANNAZZISI. Well, there are several different training courses, but let us take you through what an agent goes through for training. You start with your clandestine lab investigation and safety course. That is about 2 weeks long. Once you get that course under your belt and you go out, learn a little bit about labs, then they send you back for safety officer school, which I believe is another 3 to 5 days. That is advanced training. You get to learn about the equipment and how to take it apart, how to check it, make sure it functions properly; how to set up a site safety; how to make sure that all the toxic substances are identified and removed. Then you go into your instructor class.

That is basically the progression. It is quite a bit of training, and there is also a lot of on-the-job training. When we take our new lab agents into the labs, it is on-the-job training; we are teaching them what to do and what not to do.

The problem with labs, unlike other law enforcement, is until you have done it, until you have seen a process go bad, you really just don't know. And you are working in very restrictive suits. You do an entry where a lot of times your vision is restricted because you are wearing respiratory gear. You have to operate in these big bulky suits; you have to be very careful. There is always an inhalation problem, where you could inhale toxic substances. It is just a different type of law enforcement. It is a very different type of law enforcement.

Mr. CUMMINGS. Let me ask you this. If you were up here and you got people in your district that are suffering tremendously with regard to meth addiction, and you see the labs all over the place, what would you do? I mean, in other words, is there something that we can do that we are not doing? Because that is the bottom line. Is there something that we as Members of Congress can do? We obviously have bad numbers, and the problem is worse than what we think it is.

Clearly, this drug is destroying a whole lot of people. I am always amazed when I go into these various counties outside of urban areas and find out how many people are involved in drugs. And they serve their time, maybe they get caught; they can't get jobs, they can't support their families, and then they are back in jail again. Communities destroyed; families paying out money,; good, hard-working people trying to keep their kids going, trying to stop them from committing crimes, so they are coming out of their pocket with money that they could be paying their mortgages and buying food with and medicine or whatever. So it is a tremendous drain on our society.

I am just trying to figure out what can we do to try to address this problem that is just really going out of whack? What would you do, more than what we are doing?

And then just one tag-on question on that one. You were talking about the Federal Government should wait and see how these State laws work out, and I think that is not an unreasonable proposition. The problem is that there are too many people suffering in the meantime.

And I am just wondering how long is long enough to wait? I am assuming we are going to get some people come up here saying how great their State law is working, and I am just guessing they may say the Federal Government ought to be doing this and helping out and maybe making this across-the-board so that you can help us in our communities. And since you won't be coming back up, I just want to get you to answer that.

Mr. RANNAZZISI. Well, personally, I believe that looking at the data for about a year, if we could look at a year's worth of data, I think that will give the statistics enough time to stabilize and we could make a good determination of what impact it is having on the community. Obviously, if the lab seizures significantly decrease within a year, then we should look at that legislation strongly.

But what we do also see is peaks and valleys, and it might not stabilize down; there might be another source of that pseudoephedrine coming in somewhere. That is why we always like to wait to make a determination, to make an informed determination. For me to come back here and tell you I believe that this is the way to go, I think it wouldn't be prudent for me to say, at this point in time, this is it, this is what we need. Is it promising? Absolutely it is promising.

But I don't think I could sit here today and tell you that, at this point in time, with what I have, the statistical data I have, that is necessarily the answer. It is a very promising piece of legislation. I know the legislation you are talking about. But at this point in time I don't think we have enough data to make that determination.

Mr. CUMMINGS. To the first part of the question, what would you do? Is there something that we can do more than what we are already doing?

Mr. RANNAZZISI. Well, obviously, there is an awareness issue, getting the retailers to understand that this is extremely dangerous; allowing people to walk into a store and buy 10, 15 packs of blister-exempt products. Obviously, if you are buying 10 to 15 packs of blister packs, I just can't imagine you have that bad of a cold; I think that you are doing something else with the drug. And if retailers would understand that, they would limit.

About 3 years ago, when I was a section chief in the Dangerous Drugs and Chemicals Section, I sent two of my guys into a local place. I said, here is $500, see how much pseudoephedrine you can buy; and they basically came back with a bag full of pseudoephedrine. They paid $350 for it and no one looked at them, no one said boo.

So I think the one component is the retailers have to be our partners. The retailers are going to have to stop allowing people to walk in and purchase quantities, large quantities. I think that is part of the issue.

Mr. CUMMINGS. I just wanted to leave you with this. I never thought I would go all the way back to when I was 16 with regard

to this issue, but when I was 16 years old, I worked in a drug store, and I remember I didn't even understand Robitussin, but I remember people used to come in and buy Robitussin, I mean, like seven and eight bottles of it. Now, I knew people had colds and everything, but I thought that was a bit much. But I didn't know. Come to find out they were buying Robitussin to get high. And when I figured it out, I mentioned it to the fellow, who now is deceased, who owned the drug store, and he was saying you have to understand, I have to make a profit.

I would hope that we would be able to get the kind of cooperation from the drug stores and whatever, but I am not sure that is enough. And I guess that is the frustrating part of all of this, as I listened to all of you, and perhaps the witnesses that will come later will help us, but I can't believe that we have to sit and wait while all this destruction is taking place. Maybe I am just too impatient, but we have one life to live; this is it.

Mr. RANNAZZISI. And I understand your frustration, sir. I have been working lab cases as a diversion investigator and agent since 1986, and I have watched the progression of this problem. I have seen them go from phenyl to propenol and phenylacetic acid to ephedrine to pseudoephedrine, and all the weird combinations in between. It is a very frustrating process, and no one is more frustrated than me, because I have to go out into the communities and talk to the local officers and hear their problems. And they are problems, they are serious problems, because they care about the people they protect and serve. At this juncture, though, we have to look at all different types of legislation; we have to see what is going to be the most effective thing before we can sit here and make a determination.

Mr. CUMMINGS. Do you think the Office of Drug Control Policy, for example, is doing enough in regard to prevention? I mean, when you hear the stories like Mr. Mica talked about, the baby being put in the microwave, we have heard all kinds of stories. If some people could just see films of things that people do on meth, I just wonder whether it would make them think twice before they even got involved in it.

Thank you, Mr. Chairman.

Mr. SOUDER. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

I would like to kind of talk a little bit about the training. And I want to say that the Department has worked very hard to expand the training opportunities, but there are still barriers to many law enforcement receiving the training. Do you have or can you make available to the committee how many—I will use my State for an example—how many sheriff's offices through the counties, how many municipalities have taken advantage of the training, the followup training that is involved in it?

Because what we are seeing is people are going out and getting trained on it, but there are so many other demands, State cuts occurring in law enforcement and other things, that we don't have maybe as many people taking advantage of the training as we realize, just as Congressman Cummings was talking about really knowing the numbers of people who are incarcerated, as the sheriff pointed out; how many children are being impacted in social serv-

ices and everything like that. We need to get a handle on this for the numbers, and I don't know if you have data available, if you could get it to the committee.

Mr. HERRAIZ. Mr. Chairman and Congresswoman McCollum, we certainly would be happy at the Department to get you that information. I would like to followup, though, as to the training aspect and share with you just a better snapshot of what is actually happening.

It is imperative, as I mentioned in my testimony about the rural jurisdictions. Too many times sheriffs' deputies will be going into a scene that they are going there for something else, and they have no idea that they are going to encounter a meth lab. It could be a protective service order or something that they are going to serve, and they do. And if they have been improperly trained, we have already put their life at risk.

So what is important for us to look at is to get to Congressman Cummings' issue as far as what is it that we could do differently while you, in the meantime, continue to look at the legislative remedies. I think it is important for us to expand our training efforts.

I mentioned to you, again in the testimony, that we are going to triple, and we are doing it currently, triple our methamphetamine training at a State level. It is at a State level in the sense of those who receive our funds, because that is our point of contact, to provide it for the locals. So if you can envision that in 12 States this coming year, for the first time, the Bureau of Justice Assistance will be able to offer that training to all local law enforcement through the State criminal justice entity, this is a huge step forward.

For us to be able to, in that training, educate law enforcement officers on a traffic stop, as an example. When they pull over someone's car for a speeding ticket, what have you, and approach the car and they see these chemicals in the back, many law enforcement officers have no idea what they are actually seeing. So it is imperative that we educate the law enforcement officers.

As was mentioned from DEA, it is imperative we educate pharmacists and clerks in facilities, whether it be a retail facility or a drug store chain, what to look for so that they can in fact alert law enforcement. Training is something that we can do more of, and that is public education as well. I think that so much of that can happen.

In my own home State we found methamphetamine labs in the back of trunks at rest stops. So it is a pervasive issue, but I still think there is much more that we can do through training and education.

You had referenced meth in the context of treatment, and when you are looking at facilities, Mr. Chairman, you referenced the county facilities in your community. In the Residential Substance Abuse Treatment Program that our agency runs, there are resources to actually invest back into the State and local communities so folks can receive treatment while they are incarcerated, so we don't maintain that revolving door.

We can continue to make utilization of the Regional Information Sharing Systems that are out there that the Department of Justice funds because as we know if an epidemic occurs, if it is in Fort

Wayne, IN, it will soon be in Van Wert, Ohio. So it is important for us to continue to educate, and the best way to do that is through law enforcement information sharing systems such as, in this case, the RISS network that is funded by the government and administered through our office.

So, again, we can get you more specific details on who has been trained and what is available. I can tell you the LLEBG resources and the Byrne resources are heavily involved in training initiatives for law enforcement, as well as funding the majority of the law enforcement multi-jurisdictional drug task forces that are out in the country.

Ms. MCCOLLUM. And that is good, and I support the dollars for doing that, but sometimes I have found that other law enforcement issues aren't funded in order to increase funding into another program, and we need to be cognizant of not turning our back on another potential source of crime to fund another one.

I will use Minnesota as the example. Ten percent of the methamphetamine, to the best of our knowledge, is from the small labs; 90 percent is what is coming in. Now, of that 10 percent, we need to address it aggressively, we need to continue to work with our retailers on that.

But to just focus overwhelmingly—and each State is going to be different—for that 10 percent, when 90 percent of it is what is coming in, and we are seeing an increase on that, what do we need to do to stop that 90 percent coming in over the borders? I mean, we are supposed to be at heightened alert for activity now with homeland security, with what is going on with our borders, and when we see 90 percent of it not being produced locally, but coming in, and the term "farm Mexico" was used by my law enforcement, I think we still have a huge problem going back to homeland security.

So where is the integration going on with that? What do we need to be aware of in Congress to make that more effective? Because if we can't keep out methamphetamine, how are we keeping out terrorists?

Mr. RANNAZZISI. Well, ma'am, to start, I don't think we are concentrating just on the small labs. I think the small labs are important because the meth coming from Mexico or other countries is produced and it is in the marketplace. When these people actually make methamphetamine in STLs, it presents a great problem for the health and safety of the community at large, and then that——

Ms. MCCOLLUM. Sir, I understand that fully, and that is why I prefaced it. I don't take away the seriousness of the 10 percent. I have law enforcement officers who have had to retire early because of going into meth labs and literally having their lungs destroyed. I take this very seriously. I had a constituent who purchased a home, who ran a daycare in it, and it wasn't disclosed in their retail. I understand that. I support the actions that the committee is taking on this; we need to focus on it.

But in Minnesota, when 90 percent of the methamphetamine is coming in, the prisons are full, there is no treatment facility, we have children who are now in our social network system. I also want to know what we are doing as a country to decrease the

amount of methamphetamine that is coming in illegal into this country.

Mr. RANNAZZISI. Well, to begin with, we are working with our foreign counterparts at the chemical-producing countries. We are trying to track the chemical shipments from places like China and Germany and India into those chemical-producing countries. We are actually asking for voluntary stop of those shipments. We are notified of the shipments; we know where they are going and we know where the methamphetamine is being produced. Say Mexico, for instance. We know that Mexico has several production laboratories down there. We are working with the Mexican authorities; we are actually training the Mexican authorities in clandestine laboratory enforcement so they can go out, find and identify these labs, and dismantle them.

Unfortunately, when the problem moves outside of domestic boundaries, we have to work in conjunction with our international partners, and we are doing that. We are doing that in Mexico and abroad. It is difficult to shut down the border for methamphetamine, just as it is for cocaine and heroin, because the trafficking groups generally don't send one huge load through one particular port of entry.

What they do is they find very novel approaches to move a contraband into the country. If I produce 300 pounds of methamphetamine, I am not going to move them all through one port of entry; what I am going to do is split the load. That way, if I lose two components of the load, I still have two to make my profit. And that is what is happening.

But we still do have superlabs here as well. Not to the extent that we had 2 years ago, but we still have production labs. So we are working the production labs domestically on an enforcement basis with DEA and our local and State counterparts, and then we are working abroad in the chemical-producing countries, where the precursors start, and then in the production countries, such as Mexico, where it is being manufactured.

Ms. MCCOLLUM. Mr. Chair? I think that because they are two very serious ways in which people access these illegal drugs, both the small labs here and, as the gentleman pointed out, there are some large labs here, but also the international trafficking of this over our borders, at a time when we believe in Congress that we are spending a lot of money trying to make our borders more secure. Both of those maybe need to be separated out, as well as this is such a big topic, maybe what we need to do, Mr. Chair, with your help, is to break the next set of hearings down into smaller components so we can really wrestle and get into what we need to do congressionally to put an end to this problem.

Mr. SOUDER. I appreciate your suggestion, and as we pursue the meth problem, that is a good point. I want you to know, as well as the other members of the panel and those who are listening, that we are having a major internal battle which I think, based on everyday changes, that we have made some progress on. Speaker Hastert has been taking the lead. Obviously, border control and homeland security, the narcotics part and homeland security are totally interrelated; they are the same people on the border.

And one of the arguments we are having on the so-called 9/11 Commission bill is a series of amendments that I had in the Homeland Security Committee that the Speaker is advocating to strengthen the Air and Marine Division inside Border Protection, which is danger of being gutted; to strengthen the Counternarcotics Office that didn't even have anything but a detailee there, even though Coast Guard, Border Patrol, Customs, those legacy agencies are the major part; and to also take a number of other steps.

We have seen the Shadow Wolves in effect disbanded, which is a critical part on the Arizona border, and we cannot talk about how we are going to control the borders if we disband the anti-narcotics operations inside Homeland Security. The Department of Homeland Security has to understand that if they are in charge of the border, narcotics is part of their mission. And this committee has been taking the lead, and we need to continue to push that part of it.

In addition, clearly, if we lose these court rulings on the drug dogs, this is a disaster at the borders. There has been a local hearing that is going up toward the Federal level that would challenge the propriety of drug dog hits at the border, and that is one of the only ways that we pick up the random, if we don't have a tip. And if we don't have control of the border, anything else we talk about becomes more or less irrelevant.

I need to ask a series of questions here which we may not have all the answers, but I want to make sure some of these get in the record, and we will have some additional questions, because we are working toward a package and also what we should focus on in hearings in this next year. And I want to followup directly with one of the things that Ms. McCollum just asked Mr. Rannazzisi.

The Oregonian newspaper reported that DEA has not actively sought information or cooperation from manufacturers or law enforcement authorities in India, one of the major pseudoephedrine exporters. The Indians, however, claim that they are very willing to work with DEA to address the diversion program, including by providing DEA with documentation about exports to third countries, such as Canada. Does DEA plan to increase its efforts in India and elsewhere to monitor and track the pseudoephedrine exports to third countries?

Mr. RANNAZZISI. We do work with the Indian government. We sit on numerous international committees where there is dialog between our staff and the Indian government regarding shipments of chemicals. I don't understand where that came from, but that is just not the case.

Mr. SOUDER. Could you provide us with how many agents in India you have working on this, roughly? I realize agents do multiple tasks. And also, in particular, the question of third countries. In other words, often we are looking directly at us, but a lot of this is coming from Mexico and Canada.

Also, do you and Mr. Burns believe that we need new import quotas or controls to prevent diversion of pseudoephedrine?

Mr. BURNS. I didn't get the question.

Mr. SOUDER. Do you believe we need new import quotas or other controls to prevent diversion of pseudoephedrine?

Mr. BURNS. Yes. I think that is something that would be very helpful to address some of the questions that you have asked and Congresswoman McCollum and Ranking Member Cummings. Let me just try and briefly state this: You have been very helpful. Ranking Member, you asked if we need to step back and look at the overall picture, and at the Office of National Drug Control Policy, that is what we try and do, and rely on good numbers for sound policy. You require it, the President requires it, Drug Czar John Walters certainly requires it.

And what we know from the household survey and from monitoring the future is that there are currently 19.5 million illegal drug users in this country. Some of the most recent numbers. Seventy-five percent singularly or co-use marijuana; about 6 million are using illegally prescription drugs. That is a 150 percent increase in 5 years. That is a problem. About 3 million cocaine; about 1.5 heroin; and about 1.5 methamphetamine.

So why this hearing today and why the Federal Government's response so aggressively to methamphetamine? For all the reasons that you have stated. We could be here all day, and I could try and respond to you what we have been doing in the State of Minnesota. I have been there three times in the last year. I flew with your senator to small towns all over the State; we had hearings. I called them talk-listen sessions.

Senator Rosen has been very aggressive in gaining the ear of the Office of National Drug Control Policy. With your Governor, I recently flew around to several small towns and we listened again, trying to fix problems one at a time with respect to training, literally getting on the phone with law enforcement agencies, hooking the up with the Midwest HIDTA, which is located close by, and demanding that training information and access be made available.

Ranking Member Cummings, you have one of the best HIDTAs in the country, with Director Tom Carr. I know that you have been wholly and fully engaged with Director Walters and others not only on this problem, but others.

But the one point that I would like to make, and Mr. Rannazzisi has talked about the need to look at the numbers, it is because you demand good policy. This National Synthetics Drug Action Plan came out less than a month ago. It has taken us a long time to define what the issues are with all synthetic drugs and to come up with a plan so at some point we can come to you with numbers and with recommendations that are appropriate.

And I am going to chair a synthetic drug working group; the Plan requires that be set up within 30 days, and the first meeting will take place within the next couple of weeks. And then I hope, and I say this to all of you, that we will be able to come back, as Mr. Rannazzisi has said, with good numbers so that you can make good decisions based on sound policy.

Mr. SOUDER. We need to get to our second panel, but I have some very specifics that I want to have on the record. Did DEA support new import quotas or controls to prevent diversion?

Mr. RANNAZZISI. I am sorry, sir, could you repeat that question?

Mr. SOUDER. Do you support new import quotas or other controls to prevent diversion of pseudoephedrine?

Mr. RANNAZZISI. I believe that is in the National Drug Synthetic Action Plan, and I do believe we support that, absolutely.

Mr. SOUDER. Another question has to do with Glowtel. There have been lots of news stories around the country that says when Glowtel is added to anhydrous ammonia, it dyes it bright pink. Apparently, the bright pink color transfers to any meth made with anhydrous ammonia and actually stains any users of the drug. Should the Government promote the use of this additive?

Mr. RANNAZZISI. I know about the additive, I just don't know enough to promote or tell you that it is a good program. I do know that there are a couple of other studies out there, including University of Iowa——

Mr. SOUDER. Are you investigating this or is ONDCP or Justice?

Mr. RANNAZZISI. I believe our lab program is investigating it, our forensic laboratory program is looking into it.

Mr. SOUDER. Can you have somebody respond to the committee on any investigations on Glowtel?

Mr. RANNAZZISI. Yes.

Mr. SOUDER. Also, The Oregonian newspaper said Pfizer has announced it would soon introduce a new form of Sudafed which contains, instead of pseudoephedrine, a compound called phenylephrine. And you, earlier, just referred to some acid that sounded like it was the same basic component, you said phenyl acid?

Mr. RANNAZZISI. Phenylacidic acid. It is a different precursor. It was one of the primary precursors used way back.

Mr. SOUDER. So do you believe that such chemicals like that could prevent meth use, or will they be able to transfer like they have transferred from ephedrine to pseudoephedrine?

Mr. RANNAZZISI. If we are talking about the drug phenylephrine, our lab has done studies with phenylephrine, and they do not believe that you can manufacture methamphetamine from that substance.

Mr. SOUDER. So that becomes a very interesting question, because there may be more than one way to tackle this problem.

We have some other written questions I want to submit, but I want to say both to the Department of Justice and the CTAC Program that what we have heard in State after State from law enforcement officials is they appreciate the training. Their No. 1 problem right now is not the training. They don't have cleanup equipment. In CTAC or from Bureau of Justice Assistance, these mobile labs are very expensive.

What is happening is we are freelancing in the appropriations process. I, for 2 straight years, have gotten money for Indiana that way; Tennessee has gotten money for their State; Hawaii has gotten money for their State. What is happening, because, bluntly put, the administration is not responding, in my opinion, to what local law enforcement is asking, individual Members of Congress are freelancing and earmarking your appropriations.

And we need to look at and listen at the grassroots level; otherwise, we are going to have chaos in our appropriations process. With no national drug control plan, we are going to have individual Members of Congress responding to what they are hearing from the grassroots level; and that is one thing that we need to look at in the mix of the equipment and how to do that.

Does anybody else have anything on the first panel?

Mr. CUMMINGS. I just have two questions.

And I will submit some written questions, gentlemen. I want to thank you for your testimony.

Mr. Herraiz, do meth addicts present any unique problems with regard to treatment, being amenable to treatment? Do you know?

Mr. HERRAIZ. Methamphetamine?

Mr. CUMMINGS. Addicts. In other words, I am thinking about treatment. I was just listening to what the chairman was saying, different ways to try to approach this whole issue. Do they present any unique problems with regard to being amenable to treatment? If you know. You may not even know.

Mr. HERRAIZ. Mr. Chairman, Congressman Cummings, yes. Meth is highly addictive. And those statistics are available. If you look at data from CSAP and others, SAMHSA, you will find statistics that will show that. That is a correct assumption.

Mr. CUMMINGS. The reason why I mention it is because I am trying to figure out the drug courts and all the things that we are trying. I am just wondering if we need to look at that. An maybe the folk coming up will mention something about that. But I was just trying to figure out whether they are more difficult to treat. Because I have been a big proponent of treatment. I just want to make sure that we are doing what we need to be doing in the area. And I am sure somebody will address that.

Mr. BURNS. Congressman, if it is helpful, your appropriation to the President's Access to Recover Program, a grant was made to the State of Tennessee, and pursuant to that grant they are in the process of answering the question that you just asked. Currently, everything is anecdotal. As I travel the country, programs are from 7 days to a year and a half.

Mr. CUMMINGS. Thank you all very much.

Ms. MCCOLLUM. Mr. Chair, to followup on that, maybe we can, if you have the time to break this down and out a little more, have someone in from CDC and NIH. And I just handed Mr. Cummings two articles. They do not feel that any of the treatment programs that are currently out there are successful at all in really addressing hardcore addiction on this.

So what we are doing is we are just recycling them through the prison population. They come back, more crimes are committed, and it is a never-ending cycle. That is why, as I mentioned earlier, law enforcement is starting to see literally in families three generations of abuse on this. So treatment and that does become a key thing we need to talk about.

Mr. SOUDER. Thank you. We have been the only State that has a 10-year tracking on this. Congressman Case asked us to do a hearing in Hawaii, because they have the biggest earmark, I think it was $5 million for meth, in the appropriations process through Senator Akaka, or I believe, Inouye. And they have actual data of different types of patterns in meth at their schools over a 10-year tracking; they have it in treatment programs as well, and they have one.

We are trying to find even programs that are geared specifically toward meth treatment, but they are hard to find. It has been hard, at this point, even to get a hearing cluster enough together

to treat it, but that would be one of our goals for this coming year. I appreciate your help with that. And it is a good idea to get CDC and some of the other groups in.

I very much appreciate your patience. We will have additional written questions for you, and thank you for your continued work in this field. We have made progress, and we shouldn't deny that, and marijuana has been fairly dramatic, which is a precursor drug for all meth users. We have made progress, and hopefully that will pay off over time. But short-term we have an exploding problem across the country that is growing faster than even our statistical ability to keep up with it in meth, and we need to respond to that. We appreciate your willingness to come today.

Mr. RANNAZZISI. Thank you, Mr. Chairman.

Mr. Souder. With that, could the second panel come forward? Mr. Lonnie Wright, Sheriff Bundy, Lieutenant Colby, Mr. Heerens, Dr. Suydam, and Ms. Wagner.

Thank you. We have a new panel to swear in. Could each of you stand and raise your right hands?

[Witnesses sworn.]

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

We have been joined by our distinguished colleague from the State of Kansas, who has been very concerned with this issue for a long period of time, Mr. Moran, and he would like to personally introduce one of the witnesses, and we will start with that witness today.

Mr. MORAN. Mr. Chairman and Mr. Cummings, thank you very much for the honor of joining you on the dais today, and I am here to commend you for your subcommittee's work. I know, as a Member of Congress from a very rural district, that this is a significant issue for my constituents, for my State, and, in fact, I have fought long to bring to the attention of the administration, as well as Members of Congress, that I think challenges we face with drugs in this country are often thought of to be an urban problem. Woefully not true, and particularly not true with methamphetamine. So I am honored to be here today to join you and to particularly introduce one of the witnesses on this panel.

This issue receives significant attention in Kansas. In 1994 we had four meth busts; in 2004 we will have between five and 600. When our former colleague, Mr. Hutchinson, was at DEA, he has been to Kansas to meet with law enforcement. I had the Judiciary Subcommittee on Crime come to Kansas and conduct a hearing on rural issues related to methamphetamine.

You have before you today one of our experts, our sheriff from Rice County, KS, Sheriff Bundy. The sheriff is highly regarded in law enforcement circles in Kansas and has been actively involved in law enforcement for more than two decades, and he comes from a county that, in some ways, has a larger population than many of my other counties, with, I would guess, a population of around 10,000 people in the entire county. This is one of my urban sheriffs, and we are delighted to have his perspective. And I welcome him and thank him for taking the time in his dedication to the cause to be here today.

And I thank you, Mr. Chairman and Mr. Cummings, for allowing me to join you.

Mr. SOUDER. Thank you.

Sheriff, you have the floor.

**STATEMENTS OF SHERIFF STEVE BUNDY, RICE COUNTY, KS, SHERIFF'S DEPARTMENT; LONNIE WRIGHT, DIRECTOR, OKLAHOMA BUREAU OF NARCOTICS AND DANGEROUS DRUGS; LIEUTENANT GEORGE E. COLBY, DIVISION COMMANDER/PROJECT DIRECTOR, ALLEN COUNTY DRUG TASK FORCE, ALLEN COUNTY, IN, SHERIFF'S DEPARTMENT; JOSEPH HEERENS, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS, MARSH SUPERMARKETS, INC., ON BEHALF OF THE FOOD MARKETING INSTITUTE; DR. LINDA SUYDAM, PRESIDENT, CONSUMER HEALTHCARE PRODUCTS ASSOCIATION; AND MARY ANN WAGNER, VICE PRESIDENT, PHARMACY REGULATORY AFFAIRS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES**

Mr. BUNDY. Congressman Moran and Chairman Souder, Raking Member Cummings, and other distinguished members, I am very happy to be here today, and hope to provide some insight into some tough decisions you have to make in the near future.

As Congressman Moran stated, I have been in law enforcement for about two decades in Kansas. I am a certified meth lab investigator. Matter of fact, I was at a meth lab for 9 hours right before flying out here to be with you. So I think I might be able to offer you some insights that may be helpful.

We are a very rural county; we have a population of about 10,000; we are 750 square miles. There is myself and four officers who provide service for those 10,500 people, which is representative of about 75 percent of Kansas law enforcement. And I think if we would look at it even beyond the boundaries of Kansas, that is not so non-typical for western United States once you leave this fine area.

We do have a serious methamphetamine problem. One of the reasons is the very qualities we enjoy is our agricultural nature, the wide open spaces. The things that are most appealing to those involved in producing methamphetamine draws them to our county. We don't have the resources to do a lot with that, given the five people, so we came up with a program that is called Meth Watch in Kansas. I may briefly tell you how that works for us. And it simply was a recognition and an admission by myself that my resources were overwhelmed with the problem.

We went to the community and said, we need your help. We educated the citizens on the very problem with methamphetamine for our area. And once we had got them to partner with us and see how large of a problem this was, the very scope of it, how it affected them and their taxes, and overwhelmed the resources of law enforcement, that we weren't responding to them in a timely manner they wished, they were very eager to partner with us in this battle against methamphetamine.

The next group we brought into that were the retailers. And the interesting insight to that was that they actually were calling me, asking what can we do, because we had such tremendous support

from the community, as well as from the local media, on really detailing, covering all the problems that we were encountering and just the frequency and the amount of work we were having to put into methamphetamine investigations. So retailers came on board very easily and anxiously, and wanted to partner with us. And the community had an expectation of those retailers to partner with them and law enforcement in this very program.

We made cases through that with great regularity. If it is not just the retailers reporting suspicious transactions or odd purchases, or they recognize just the very ingredients you have talked today in the shopping carts coming through the lines, if they aren't calling, we are getting calls from the citizens of Kansas that have been trained.

And when they are in line, they notice these shopping carts behind them, or they will notice the peculiar behavior of a multitude of individuals coming in and splitting up and buying these purchases and then lining up in the checkout line. So it has been very effective for us in Kansas to approach it at the community level through a very strong education piece that was only possible by a small grant through the Kansas Methamphetamine Project of $3,000 is really what initiated this Meth Watch program. So I don't want you to underestimate the value of the Federal dollars coming down the State levels, and from the State level to the local level, and what $3,000 can be, because it has had a huge impact in my county.

My neighbors to the south, the great State of Oklahoma, have introduced Schedule V, and I know the early data says that is working well for them. I know there are some border counties in Kansas that are reporting an influx of Oklahoma residents coming up to purchase that, and I hope it works.

I am a little guarded, as you have heard earlier, on that, because my experience in 20 years, it is very hard to regulate or legislate addiction; and relocating products, limiting products, it is still a very hard thing to take away from these people, because I work with them everyday. Truly, a portion of every workday is dedicated to methamphetamine work in a county my size, which hinders the civil process and the jail operation, and all the other services that a sheriff's office is forced to provide.

So any tool we can come up with that helps is great. The grants were great, not only on the education front for the Meth Watch, but also in my training. I am the only meth investigator for clandestine labs in our county, which puts me at safety risk, as well as the citizens to only be able to provide one officer for that service. And, unfortunately, there has not been funding available in our State to train any more of my officers, so I can't partner up with another officer in these dangerous situations. So I encourage you to expand the grant portion of your investigation here, because it is critical to local law enforcement.

You asked earlier about Glowtel. I would very much support that. We take an anhydrous ammonia theft daily and we recover anhydrous ammonia in any kind of container imaginable. So anything you can do to help the rural America on that front would be greatly appreciated too.

In summary, it is just truly all my life has become is an officer. When I started in 1979, I was in uniform like this now. More often than not I look like a spaceman working for NASA in a suit with breathing apparatus and testing equipment, things like that. So I would encourage you to listen carefully today and be very open-minded, and come up with a comprehensive approach that would assist rural law enforcement. And I would be happy to answer your questions at the conclusion.

[The prepared statement of Mr. Bundy follows:]

# Congress of the United States

House of Representatives
COMMITTEE ON GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
Washington, DC

*Prepared for the investigative hearing held November 18, 2004 entitled*

***"Law Enforcement and the Fight Against Methamphetamine"***

*conducted by the United States House of Representatives*
*Committee on Government Reform*
*Subcommittee on Criminal Justice, Drug Policy, and Human Resources*

Offered for consideration by

Sheriff Steve Bundy
Rice County, Kansas
1482 US 56 Highway
Lyons, Kansas 67554

Distinguished members of Congress, panel members, guests and other interested parties, I am honored to have been asked to assume a role in this undertaking. I applaud the interest of this subcommittee to begin a dialogue of all community members who have an interest in making our society less burdened by the horrible drug known as methamphetamine. I have been involved in the Kansas criminal justice system for over twenty two years in roles which include city patrolman, deputy sheriff, D.A.R.E. officer, probation officer and currently serve as sheriff of Rice County, Kansas. Rice County covers 750 square miles for which I, along with four other deputies, are responsible. However, I am the only technician certified to investigate, dismantle and clean up clandestine methamphetamine laboratories. I routinely initiate action to bring methamphetamine producers to justice through the seeking out and execution of search warrants. The meth problem consumes a majority of my time each day. When we assemble the community affected by methamphetamine, it brings many players to the table due to the unique characteristics of this problem. Why is that?

First, the process by which this drug is produced is readily available. It does not discriminate, nor does it require any specialized education or training. The manner or "recipe" used to produce methamphetamine is readily available on the internet. Sharing "recipes" is a source of pride for "cooks" who take great satisfaction in making improvements to old standards, in discovering new techniques to increase yields, and in creating a product with a higher purity level. There is a sense of showmanship amongst those involved in the production of methamphetamine.

Secondly, the items or "ingredients" necessary to manufacture methamphetamine can be easily obtained in many retail outlets. There is nothing required in the process that is not stocked in most stores in all towns across the United States. The products are common household goods which can be purchased without so much as the raising of a brow by the clerk operating the register. This fact draws retailers into the process of being a source for obtaining necessary precursors, reagents and solvents to manufacture methamphetamine with little or no awareness as to the role they are playing.

Thirdly, the drug itself knows no social, ethnic or gender boundaries. It victimizes all people, regardless of age, regardless of their address, regardless of their marital status. It does not care if you have children or dependents. With one or two encounters with the monster called methamphetamine, it will own you. It will control you. It will make your decisions for you. It will beckon you to steal, to abandon loved ones, to neglect your children, and to disregard your responsibilities such as work and family. It will cause you to seek medical attention. It will force your family to turn to social support systems for assistance.

Often people fail to appreciate the tremendous social costs caused by methamphetamine. It consumes a large portion of the criminal justice resources all across America. Not just in the investigative hours dedicated to combating the manufacturing of the drug but also in the judicial system. Property crimes increase as those who are addicted struggle to get their next fix. They turn to committing crimes to feed their addiction. There are a high percentage of those on probation and parole who have had involvement with the drug. The penal system is overburdened with those who manufacture, distribute or use of methamphetamine. Regrettably, there are not enough treatment beds in any area of the country to offer timely and adequate treatment opportunities. State social systems are being burdened by the influx of children of parents who have fallen victim to methamphetamine. They are now being referred to as DEC (drug endangered children). Specials programs are being created all across the country to deal with this new segment of society. Families are more victimized by violence and neglect. Caregivers begin to focus more on the drug than the family unit.

Law enforcement is looking for effective, efficient interventions to help our communities in the battle against methamphetamine. I would caution all of us from looking for the magic bullet, the quick fix, or the "too good to be true" solution. The scope of this problem is of a magnitude difficult to comprehend. There are many ideas, proposals, and suggestions offered in many forums. I will share an intervention being utilized in my jurisdiction which has proven effective. It has been implemented with minimal cost and has had many positive effects. This program is called *Meth Watch.*

*Meth Watch* is a community based program. It creates partnerships among citizens, retailers and law enforcement. It is through this comprehensive approach that

its success is found. *Meth Watch* was started several years ago based in response to the frustrations of two narcotics officers. They were becoming burned out and desired to spend more time with their young families and less time pursuing meth cooks. We took this concept and formulated a community team that was made up of people from all walks of life. It was comprised of law enforcement officers, prosecutors, retailers, school counselors, agriculture representatives and health professionals. We began with an initiative that involved educating the community on the problems, dangers and social costs associated with methamphetamine in our area. The media assisted in excellent coverage of all methamphetamine investigations. Mailing stuffers were created to inform the public. These stuffers were inserted in mailings already being sent by other entities such as banks and utility companies, saving the expense of postage. We held public informational meetings to expose the community to the facets of the meth problem. These meetings targeted those in positions likely to encounter methamphetamine production, such as utility meter readers, rural township road maintainers, mail carriers, home visitors such as social workers, teachers, and medical professionals. After we felt like we had created a heightened awareness, we began with the retail piece. This involved meeting with retail owners and managers to explain to them how their business was being exploited by those involved in the production of methamphetamine. We identified those retailers who had products used in the process. We asked them to join with us to combat this epidemic. Over ninety percent of those identified retailers agreed to partner with us. They were educated on the products in their inventory which are used in the process. We trained them on suspicious transactions. Behaviors and ploys used by those collecting the necessary items for the manufacturing process were explained. We showed them how to minimize loss due to shoplifting by relocating targeted merchandise near registers and limiting the number of items displayed on shelving units. We suggested limiting the number of items, such as medicines containing pseudoephedrine, that a consumer may purchase during a single visit. A training video was distributed for use when training employees on what to be aware of. After these steps were completed their stores were ready for marking. Decals were placed on the entrance doors clearly stating they participated in the *Meth Watch* program. Products used in the process are clearly marked with shelf tags to warn those

attempting to collect them that employees are watching such purchases. Colorful posters showing all products used in the process are posted in break room areas of the store for employee's constant review. Information sheets are placed at check out stands for distribution to consumers who are interested in the actions being taken by the store to impact the methamphetamine problem. And finally, employees are trained to notify law enforcement immediately of any suspicious actions or purchases they observe. They are encouraged to collect and report descriptions of the persons involved as well as any vehicles they observe which may being used by the subjects.

Has *Meth Watch* been effective? The program has been very successful on many levels. Not only has it resulted in numerous arrests directly attributed to reports by retail clerks, as well as citizens, but it has formulated many beneficial partnerships. Relations between law enforcement and the community have never been better. Grants have been awarded for the development of programs directly based upon the collaborative efforts observed to be ongoing within the community created through the *Meth Watch* program. Through arrests of those involved in the production of methamphetamine, I have been told during interviews that they do fear being apprehended in retail outlets marked with the *Meth Watch* signage. The signage, when coupled with the high sense of paranoia felt by the addicts, is an effective tool. Individuals report driving to other areas where they felt less likely to be noticed, reported and arrested. We took the *Meth Watch* concept a step further than marking the retail stores- we marked the communities of the county. Those traveling our highways will see a *Meth Watch* sign posted at the city limits of our communities. We want to inform those traveling from community to community collecting products necessary for the production of methamphetamine that they need to keep on driving. That in this community they will be watched, their purchases will be noted and, if suspicious, law enforcement will be contacted.

We have found that through a community effort a problem can be addressed and a difference can be made. The implementation of the *Meth Watch* program was made available through a small grant of several thousand dollars. It is amazing what a small amount of seed money can do when combined with resourceful people who have identified a problem and have a plan of action.

Another approach being considered across the country in the rescheduling of pseudoephedrine. This is an effort to make obtaining the precursor much more difficult for those involved in manufacturing methamphetamine. With no doubt this will make it more difficult for *everyone* to obtain pseudoephedrine. While this will have a positive impact upon the battle against methamphetamine it will cause inconvenience upon society. The question is can you legislate addiction to methamphetamine? Has the increase in the term of incarceration for conviction of such crimes been effective? Will the relocating of the drug behind the counter and the required signature to purchase it be effective? I do not have definitive answers to the posed questions. I know that addicts will still need pseudoephedrine regardless of the barriers placed between them and it. I do not know the lengths they will go to in their efforts to obtain it. I would offer that without an electronic database on a national scale to identify and track suspicious quantity and frequency purchases of pseudoephedrine and ephedrine little may be gained. It is proven that those seeking the drug are willing to travel to obtain it so signing a log sheet at each pharmacy may do little to eradicate this unless there is a networking system included to identify such procurements.

I am encouraged by the development of a newly formulated anhydrous ammonia which will continue to make it a viable source of fertilizer in the agriculture community, yet make it ineffective when used in the process of manufacturing of methamphetamine. The theft of anhydrous ammonia in rural America is a daily occurrence and creates an environment which is very dangerous for those engaged in farming. I have recovered anhydrous ammonia in many varied containers ranging from fire extinguishers to insulated jugs. The news of an additive in anhydrous ammonia which discolors those who come into contact with it is an excellent tool for law enforcement. The product can be added into the anhydrous ammonia at a very minimal cost yet it offers excellent evidence towards the successful arrest and prosecution of those involved in the production of methamphetamine.

I have directly experienced positive results through legislation making the penalty for being involved in the use or production of methamphetamine severe. In Kansas, we have created laws which place those convicted of the crime of manufacturing methamphetamine behind bars for up to eleven years. Given the highly addictive nature

of the drug and the lack of success in the treatment of those addicted to methamphetamine, it is my experience that the only sure way to slow the spread of this crisis is through incarceration.

I do believe that the most effective course to be considered must be multi-faceted and comprehensive. I do not believe that one direction or one approach will offer success in this effort to reverse the current trend in our country in the production and use of methamphetamine. I feel the best chances of success will come at the local level with some national direction and leadership. The greatest resource found in our country is our people. I know we must include education, consider legislation, and continue holding people accountable for their choices to reverse this trend of drug use.

It is my hope that through the information shared in hearings such as this a course of action can be charted to assist all local, state and federal criminal justice partners, all communities, all families and individuals who feel victimized or impacted by this horrific drug.

Mr. SOUDER. Thank you. And as I earlier stated, all of your written statements will be submitted in full of any witness.

I want to depart from our normal procedure just a little, because we have not, in a Washington hearing, had anybody in detail explain who does it here. We have done it in the field hearings; we hear it all the time. You said it took you 9 hours. Why did it take you 9 hours?

Mr. BUNDY. Because it was a small lab, honestly. There have been labs that I have been at for 30, 32, 35 hours without a break, without stopping. It is just the complexity of the process; the hazards that are left behind that need to be remediated correctly; to collect new evidence. Most of these scenes have hundreds of pieces of evidence that have to be photographed and documented and collected. There are disposal orders that have to be sought from the judicial system to allow us to get rid of some evidence that is just too hazardous to store for trial.

It is just a very large undertaking, and that is even further complicated by the rural nature of Kansas, in that oftentimes these sites are 15, 20, 40 miles from other resources. So when you do get a contracted company to help with the final disposal of the identified hazards, it just pretty much eats into an entire day.

Mr. SOUDER. Well, I thank you for that, because we have heard testimony across the country that particularly in small, 10,000, up to 80,000 counties, 4 to 9 hours. Mr. Wright told me out in the hall earlier 12 hours; and Oklahoma has been as long. You can go out there, your entire drug task force is tied up, in some counties your entire police force is tied up all day long. It means nothing else is protected while you are out there dealing with one tiny lab. And we clearly have to have some way to kind of look at this problem in a macro way, as well as in the micro way.

Now I would like to recognize Mr. Lonnie Wright, who is the director of the Oklahoma Bureau of Narcotics and Dangerous Drugs.

Mr. WRIGHT. Thank you, Chairman Souder, Ranking Member Cummings, and the rest of the distinguished members here.

I am probably the only guy that will be able to give you good news today. In Oklahoma we have regulated pseudoephedrine, and methamphetamine labs have dropped off dramatically. But before I talk about that and the law, I would like to tell you why we took such a step as regulating pseudoephedrine and making it a controlled substance.

Like many other States, in our region, anyway, beginning in 1994, we have seen a steady increase in methamphetamine laboratories. I think the last few years we have worked over 1200 laboratories. And I know you have discussed methamphetamine lab reporting. In my opinion, these numbers are grossly under-reported. I can tell you that in many cases, when deputies in rural areas encounter boxed labs and trash that is often dumped by people who manufacture every few days, they don't wait 19 hours or 12 hours or whatever, they simply dump it in the trash. So those kind of statistics typically aren't reported.

We don't see superlabs in Oklahoma; we haven't since the late 1980's. All we see are addict-operated laboratories. These laboratories are operated by people who are simply supplying their own addiction, and that of a few of their close friends. This is an addic-

tion-based crime that we are encountering, not an economic-based crime like in years past. These are not laboratories with giant flasks that look like a chemistry department at a university like we have seen in the past; these are a few fruit jars, some coffee filters, and some household products. And at the onset of this epidemic, I think a lot of times law enforcement stumbled across these products and didn't really know that they were in a meth lab. Sometimes it is difficult for the untrained person to tell.

In Oklahoma we have spent countless millions of dollars. We have done all the traditional things that we thought were necessary to treat the symptoms of this problem. But, yet, every year, as you can see from our graph, those numbers just go up and up and up, and seem to have no end in sight. Our jails are full of methamphetamine addicts; our treatment beds are full; our resources are strained to the hilt. We were pretty desperate and simply didn't know what to do.

We initially had a 20-to-life sentence for manufacturing methamphetamine. We had to reduce that in part to accommodate the vast numbers of people that were apprehended in methamphetamine laboratories.

One thing that I think is very important to note here, and it made a difference when we had these sort of hearings in Oklahoma, for understanding purposes: you don't mix a number of household products together and get methamphetamine. You start with pseudoephedrine that is molecularly very similar to methamphetamine, in fact, it is one O-H molecule different than methamphetamine. And you use those household products to burn that O-H molecule off in just a few short hours with this household apparatus and these products.

In reality, a methamphetamine addict looks at these cold medications on the shelf like it is methamphetamine, not like we look at it, as medicine. So that is the single key issue to focus on if you want to solve the problem. You have to keep pseudoephedrine out of the hands of those who would simply convert it in a few hours.

One of the differences, I think, between superlaboratories and addicts who buy methamphetamine from distribution networks, and those who manufacture their own is those who purchase it from distribution networks have to come up with the money. They are limited somewhat in their addiction and their ability to get as much methamphetamine as you want. When you can manufacture methamphetamine in your home for a fraction of the cost of what it would cost to buy it on the street, you can have all of it you want and it is basically pure. There is nothing to limit your addiction. So what we see is these people that are able to make as much as they want; their addiction becomes chronic very quickly. This is a terribly addictive drug, as you well know.

Prolonged chronic addiction leads to something that we have been told is called the methamphetamine psychosis. A person who has methamphetamine psychosis is clinically indistinguishable from a paranoid schizophrenic, as we are told by our medical experts in Oklahoma. They are, of course, unpredictable, and violent behavior is often a result of that unpredictability.

In that sense, in the past few years in Oklahoma, with this epidemic reaching a terrible state, the violence and the carnage asso-

ciated with methamphetamine manufacturing and addiction has really resulted in a public safety problem and an issue. I think that is one of the reasons that we focus on that in State and local law enforcement more than maybe Mexican drug cartels and the like, because it is such a public safety issue.

About a year ago we had an interim study in our legislature, much as you are holding here, and we brought in experts from all of the various disciplines to try to understand this. One thing was clear: what we were doing simply wasn't working. We basically, in essence, concluded that as long as methamphetamine addicts have access to pseudoephedrine, there won't be any diminution of methamphetamine labs, the mom-and-pop type labs that we are talking about. Our challenge, what we became: How do you keep pseudoephedrine out of the hands of those who would turn it into methamphetamine in a few short hours, while not restricting access to those who have nasal congestion? Pseudoephedrine is a nasal congestion medicine. We came up with the only solution we could, and that was to regulate it.

What we did in Oklahoma, to make a long story short, we regulated all pseudoephedrine as a Schedule V controlled dangerous substance. We moved those starch-based tablets and hard gel caps behind the counter at the pharmacy. Those are the products that we see in methamphetamine laboratories. We require customers to show a photo identification and to sign a log book. We limit sales to nine grams of pseudoephedrine per running 30-day period. We ask individual pharmacists to look at that log book and not sell individuals more than that nine grams.

And we are presently, pursuant to a COPS grant we are very grateful for, developing an online, State-wide, realtime log book that would enable pharmacists to access that data and know whether or not that person had purchased more than the nine grams in that 30-day period, thus having the ability to limit that and not let people have more pseudoephedrine than is necessary.

We made exceptions. We exempted products that we have not seen in methamphetamine laboratories that contain pseudoephedrine. Those products are the squishy liquid-filled gel caps—we haven't encountered that—and all of the syrups.

In total, the products that we moved behind the counter, say at a typical Walgreen's store, would be about 100 products, including their Equate brands. So this was really a quite doable deal.

Our legislature passed this idea on April 7th of this year. The only opposition we had after great State-wide debate was the industry; and they opposed it. The citizens of the State of Oklahoma were pretty much tired of methamphetamine and problems associated with it, and I believe supported it. I have heard very few complaints from anyone, and we think that it is quite reasonable to have a minor inconvenience to treat nasal congestion, compared to the carnage that is associated with continued methamphetamine addiction.

As you will note, and others here agree, these are preliminary numbers that we are seeing. But just instantaneously, the number of methamphetamine laboratories submitted to our State's crime laboratories dropped off by about 50 percent, and have steadily continued to drop in the months following.

For example, our 27 drug task forces that are Byrne funded and very important, by the way, around the State do the lion's share of methamphetamine laboratory investigations. In 2003 they averaged 92.4 meth labs per month; they presently, as of August, reported 32 meth labs. That is about a 65 percent reduction. The same sort of reductions have been seen in our metropolitan areas. The Oklahoma City Police Department numbers have dropped off from an average of 14.5 per month to I think September they worked 2 meth labs; I think in October they worked 4 meth labs. And so on. So we are real encouraged by this.

The bottom line is if these addicts can't have access to unlimited supplies of pseudoephedrine, they can't manufacture methamphetamine. You cannot manufacture that without having pseudoephedrine. The key to what you are trying to accomplish here is how do you keep that out of the addicts' hands.

If I could say, there is a lot of anecdotal information.

Mr. SOUDER. You need to conclude. We have given you generous time here.

Mr. WRIGHT. Sir?

Mr. SOUDER. Make a concluding statement, because we have a 5-minute clock, and I have let you about double that.

Mr. WRIGHT. OK. I am basically finished, and I apologize, sir.

We are looking at where pseudoephedrine presently comes from. Obviously it is coming from adjacent States and areas close to the border. We see people going from pharmacy to pharmacy, signing the log, and that is called smurfing. We hope to close that gap. And we have a few pharmacies that are yet to become compliant. So we are real excited about our results. And all these Federal programs you have talked about here, particularly Byrne and COPS, are very valuable to us.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Wright follows:]

**TESTIMONY OF LONNIE WRIGHT, DIRECTOR, OKLAHOMA BUREAU OF NARCOTICS AND DANGEROUS DRUGS CONTROL**

**Before The**

**GOVERNMENT REFORM COMMITTEE'S SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES**

**November 18, 2004**

## I. Introduction

Chairman Souder, Ranking Member Cummings, and distinguished members of the Subcommittee, it is indeed my honor to address you today, and I take particular pleasure in bringing you something of a success story in Oklahoma's fight against the illegal drug scourge.

Like many states, Oklahoma has spent the past decade fighting the insidious problem of clandestine methamphetamine laboratories. Researchers are learning more each day about the corrosive effects this drug has on the human body and mind, but already we know it to be among the most addictive of the street drugs, and one which breeds violence and danger, leaving in its wake permanent damage to the user's brain structures. The makeshift laboratories which produce this drug leave behind contaminated dwellings, environmental and ecological damage, and in some cases death or injury to innocent victims who are all too often children.

Oklahoma witnessed a twelve-thousand percent increase in the number of these clandestine methamphetamine laboratories seized from 1994 through 2003, with more than twelve-hundred of them seized last year. Those of us in drug enforcement spent much of that decade battling the problem on multiple fronts through strict enforcement, rigid prosecution, and by pushing for new laws aimed at helping us to apprehend and prosecute those involve in the manufacture and distribution of this deadly drug. We soon realized what the statistics above readily tell: catching them wasn't our problem, and in fact we were doing quite well at this. Our problem was what to do with the ever-growing number of these offenders once they were convicted, how to stop the massive drain on criminal justice resources which these offenders cause, and in short, how to prevent the problem rather than treat its aftermath.

Law enforcement from the federal down to the local level banded itself into a coalition. Lawmakers convened a legislative study. Our news media became interested and lent support through its editorial pages. The result was a piece of legislation which immediately cut Oklahoma's meth lab problem in half, and has become a model for almost two dozen other states considering similar measures.

## II. An Overview of the Oklahoma Meth Lab Problem

Methamphetamine is a highly addictive street drug, commonly manufactured in clandestine laboratories using a variety of household products and chemicals. Although there are a number of ways of making this drug, it is imperative to note that pseudoephedrine is required in all of

these methods. The reason for this is that *pseudoephedrine is not just an ingredient, it is the immediate precursor and in fact methamphetamine is pseudoephedrine with one molecule chemically removed.* Removing this oxygen molecule is very simple and thus "meth cooks" literally see boxes of methamphetamine on the store shelves where you and I would simply see decongestant products containing pseudoephedrine.

The meth lab epidemic emerged as a chief public safety and public health threat to the citizens of Oklahoma. In 1994, 10 such labs were seized in our state. In 2003, that number grew to 1,235. The Oklahoma Department of Mental Health reports that 11.5% of Oklahoma high school students have used methamphetamine at least once in their lifetime. Among high school seniors, that number is 13.1%. In Tulsa County, our second largest county, the District Attorney's Office reports that children have access to approximately 40% of the clandestine laboratories seized there, and that 12% of all felonies there are directly related to methamphetamine. A study of children removed from meth labs in Tulsa revealed the following:

- In 2001, 40% tested positive for the presence of methamphetamine.
- In 2002, 60% of those whose test results are known tested positive for presence of methamphetamine.
- From January to June, 2003, 89% tested positive for methamphetamine.

Because methamphetamine use produces individuals more paranoid, violent, and unpredictable than even most other street drugs, the current handling of these offenders even after their first or second arrest is contributing to the risk to public safety because they are not detained and/or treated immediately after their first arrest. This tendency toward violence is well-known among police officers, and is borne out by Arrestee Drug Abuse Monitoring (ADAM) program statistics, which indicate a high correlation between meth use and violence, use of weapons, etc.

**III. Economic vs. Addiction-Based Crimes**

Almost all of the labs seized in Oklahoma involve individuals making the drug to supply themselves and a close circle of associates. According to drug task force commanders across Oklahoma, the vast majority of the meth labs seized last year, something on the order of 95% or more, were capable of producing an ounce of methamphetamine or less at a time. Additionally, the overwhelming majority of those arrested for manufacturing are themselves addicted to the drug. We rarely see any real distribution organization associated with these groups, and while some of those arrested sold methamphetamine to support themselves and/or family members, most sold only enough to purchase additional chemicals to manufacture more methamphetamine.

Thus, these are not economic based crimes, but rather addiction based crimes. The key significance of this distinction between economic-based versus addiction-based drug manufacturing lies in the ability of policymakers to successfully combat each with traditional criminal justice tools. Drug manufacturing, trafficking, and distribution crimes are typically motivated by economics, *i.e.* the offenders are in it for the money and quite often do not use the illegal drugs they sell. When arrested, they will typically cease their criminal activity for at least

a period of time, particularly if they do not know the precise nature of the case against them and the details of how law enforcement apprehended them.

Methamphetamine manufacturers/addicts respond differently. Once released on bond, they are often arrested a second and perhaps even a third time on methamphetamine related charges before their first case ever goes to court. Due in large part to the psychosis associated with methamphetamine addiction, the probability that a meth manufacturer/addict released on bond will return to using and making the drug is near 100%, according to law enforcement and treatment professionals who deal regularly with these offenders. Consequently, enormous law enforcement and criminal justice resources are expended each year, with no apparent diminution in the number of labs seized. In many areas of Oklahoma, all available drug enforcement efforts were absorbed responding to meth labs, leaving no time for lengthy but needed complex investigations of other criminal enterprises. This allows very dangerous and sophisticated criminal organizations to operate largely unchecked in many cases due to the fact that meth lab cases monopolize police resources.

**IV. An Overview of the Oklahoma Solution**

In September of 2003, the Oklahoma House of Representatives convened an interim study of the meth lab problem. This study was requested by Representative John Nance and chaired by Representative Paul Roan, and featured testimony from more than two dozen law enforcement officers, prosecutors, treatment professionals, and others involved in the issue. The result was House Bill 2176 authored in the House by Representatives Nance, Roan, and others, and in the Senate by Senator Dick Wilkerson.

This legislation contained a number of provisions suggested during the interim legislative study, but two of these have been key to reducing Oklahoma's meth labs. First, the bill places pseudoephedrine on Schedule V of Oklahoma's Controlled Dangerous Substances List, and second, it allows most of those charged with making and using methamphetamine to be held without bond for their own protection and the protection of the public.

When this bill was signed into law by Governor Brad Henry on April 7th, 2004, the immediate effect was that tablet form pseudoephedrine products could no longer be sold in convenience or discount stores, but were restricted to the trained, responsible, and accountable hands of a pharmacist. No doctor's prescription is required to purchase these products, but consumers must obtain them from a pharmacy, show a photo identification, and sign a log. The law also restricts the amount any one purchaser may obtain to 9 grams during any thirty-day period. This 9 gram quantity amounts to several boxes of these products, and is much more than one taking the full recommended dosage during that time period would need.

Besides limiting tablet form pseudoephedrine sales to pharmacies, Oklahoma's law also addresses the revolving door posed by meth manufacturing offenders who post a bond and return immediately to the making and taking of methamphetamine. Those arrested on manufacturing related offenses are not allowed to post bail at the jail without first appearing before a magistrate. At that hearing, if the state puts forth evidence that the manufacturing crime was to support the defendant's own dependence upon methamphetamine, there arises a rebuttable presumption that

no conditions of release would ensure the safety of any member of the community. This closely mirrors federal law and effectively forces the methamphetamine manufacturer/user to prove to the court why their release would not endanger their own or the public safety.

During the first month this law was operational, an immediate reduction of approximately 40% was seen in the number of clandestine methamphetamine laboratories being seized statewide. Perhaps even more telling is the fact that drug agents in many locales of Oklahoma report that they have worked no operational labs in recent months, when they were encountering two per week prior to the new law's effective date.

The Oklahoma City Police Department has seen a 59% drop in meth labs seized from April through October compared with the same time period for last year. The Tulsa Police Department showed a 39% decrease over the same time period. Statewide, the 27 or so drug task forces were averaging 92.4 meth labs per month prior to the passage of this bill, and that monthly average is down 65%.

Despite these dramatic decreases, there are still methamphetamine labs being seized in Oklahoma. The pseudoephedrine supplying these appears to come from a number of pharmacies not strictly enforcing the 9 gram limit, from smugglers bringing it from surrounding states, and from so-called "smirfing", where criminals go to multiple pharmacies and obtain amounts which are individually under the limit, but collectively much more. This last problem will soon be addressed by new enhancements to Oklahoma's prescription monitoring law which will soon electronically track all controlled substances in Schedules II through V, including pseudoephedrine. The Oklahoma Bureau of Narcotics is presently implementing a web-based secure system which will allow law enforcement, physicians, and pharmacists to access in real time the records showing which persons have purchased pseudoephedrine and in what amounts.

The journey through researching, drafting and ushering House Bill 2176 through the legislative process taught us several lessons. First, it is essential that one studying this problem and possible solutions understand that pseudoephedrine is not simply an ingredient of methamphetamine, but is an immediate precursor and a very slight and easily-accomplished chemical change is all that is needed to change the former to the latter. Second, one must understand that the bulk of these labs are operated by addicts and that their manufacturing crimes, while sometimes accompanied by small sales of the drug, are motivated chiefly by their addiction and not by the desire to make money doing it. This in no way excuses the crime. It simply informs policy-makers that traditional criminal sanctions aimed at deterring this and other offenders do not work to offset so powerful an addiction as methamphetamine. Third, one must make the mental transition from thinking of these products as benign and ubiquitous and recognize that, through the actions of the criminal element, they are precisely the type of product which the controlled substances act was designed to regulate.

We also learned some procedural lessons. We found that law enforcement officers were nearly unanimous in both their assessment of the problem and their belief in what should be done, and that marshalling and presenting this collective opinion to the legislature was essential. We learned that the press, through reporting the facts as we know them, is key to such an

undertaking. Finally, our efforts to pass this legislation were helped enormously by the early and unwavering support of Oklahoma Governor Brad Henry. He called for passage of this bill in his State of the State address prior to the start of the legislative session, he monitored the bill's progress, and when it passed the House and headed to the Senate, he called a press conference urging its quick approval and transmittal to him without political entanglements.

**V. Conclusion**

I know that much of your study today concerns what the federal government can do to help states battle the meth lab problem, and at least three broad areas come to mind. First, policy-makers at the federal level must recognize and then help state officials to recognize that pseudoephedrine fits perfectly the statutory definition of a controlled dangerous substance because it has some redeeming medical value but a high potential for abuse. In this regard, it is no different than drugs like heroin and morphine, and more recently codeine, all of which were once readily available in retail stores until their abuse forced legislative action to relegate them to pharmacies. While one's tendency may be to view these products as simple, harmless cold or allergy medicines, the reality is that their abuse potential as an immediate precursor to methamphetamine requires some regulation.

The second thing that federal officials can do is to ally themselves closely with state and local law enforcement officials and interested policy makers to provide support and statistics. The coalition we formed in Oklahoma was well-represented by every level of law enforcement. The federal Drug Enforcement Administration provided statistics on those distributors and businesses providing pseudoephedrine in Oklahoma, information which DEA collects as a result of federal licensing and record-keeping laws passed some years ago. This statistical information was invaluable in helping us to prove the inordinately and in some cases ridiculously high amounts of these products being dumped on our streets by certain persons and companies, and played a large role in the ultimate success of our legislative efforts.

Third, the federal government should continue its current level of support to states in implementing prescription monitoring programs. The Office of National Drug Control Policy ranks prescription drug abuse as the second largest drug problem in America, and electronic monitoring programs will combat this, and at the same time allow tracking of pseudoephedrine products in states which have made it a controlled substance.

Mr. SOUDER. Well, thank you. And I wanted to make sure you had a full description of the program in, because we probably had five hearings in the country now and description, and almost everywhere we go Oklahoma's program comes up. So we needed to have a full and thorough explanation of the Oklahoma program. And we are going to have a number of witnesses here who have concerns about how we do this at a Federal level, so I think that helped lay the groundwork for it.

Lieutenant Colby is from my hometown of Fort Wayne, IN, which is a city larger than most areas that are affected by meth, as he states in his written testimony. But he has been the chief narcotics person in our region for many years, and not only has the city of Fort Wayne, but coordinates the drug task force that goes beyond the city.

You have been through crack, you have been through all different types of narcotic challenges in Fort Wayne, including just a few years ago we had this boost up in LSD, and things come and go. This one appears to be different. You have talked to me before about the importance of the Byrne Grants, about RISS, and the information network, and I just wondered if you could share some of your thoughts about what is happening in Indiana and some of the historical perspective with what we are looking at here.

Lieutenant COLBY. Thank you very much, Chairman Souder, for asking me to share my views on State and local meth enforcement today. I commend you on drawing attention to the meth enforcement challenge by holding this hearing.

We are in the midst of a crisis; last year in Indiana, law enforcement seized 1,260 clandestine meth labs. The total in 2004 will almost certainly be larger. In fact, just last Friday the Indiana State Police reported to me the State Police alone has responded to 973 labs so far this year.

I can tell you that this problem, at the moment, affects rural areas more than it does affect our larger jurisdictions. The sky-high costs of taking down and dismantling meth labs is being carried by agencies with relatively very small budgets. We have learned to be very efficient in what we do, but we know we could do better if we had some more resources. To do better, we need your help.

Alongside the devastating physical impact of meth on abusers, the saddest aspect of the meth problem is the so-called drug-endangered children issue. Investigators in Indiana often encounter children in clan lab sites. We remove these children from immediate danger and take them to local child protective agency services to make sure that these children are tested for the presence of meth and any other toxic chemicals in their bodies. Parents who subject their children or kids to these toxic waste sites are being held accountable by the use of child endangerment laws.

More than other illegal drugs, meth enforcement requires a high degree of training and specialization for the officers who deal with it. Many of our officers have received specialized training and equipment provided by Federal agencies such as DEA. This training enables us more effectively to size and dismantle clan labs. We especially appreciate the training on how to enter operating labs, taking control of the sites and halting production.

Let me give you an idea of the costs that we have been bearing in dealing with this problem. Specialized vehicles and equipment are very necessary to protect officers responding to hazardous sites and are very expensive. Appropriate training absolutely is essential, but is time-consuming and expensive. Waiting for qualified cleanup companies to arrive on the scene of an active lab takes 2 to 4 hours, during which officers who are on the payroll clock have to guard the site. They use part or almost all of a shift responding to just one meth lab. The real impact is on the bottom line. Hazardous material must be disposed of under strict government regulations.

Faced with the nature of the meth problem, we cannot afford to just stand by; we have no choice but to attack the clan labs. But the costs are enormous. We are left with little choice but to appeal to our State leaders and you here in Washington to give us a hand.

Narcotics officers throughout the State of Indiana are supporting efforts in our State legislature to pass a bill that would require Indiana retailers to demand photo identification and signature in a register book in order to purchase over-the-counter products containing ephedrine and pseudoephedrine. I can tell you that we have closely watched the efforts of the State of Oklahoma, and we are aware that meth lab seizures are down about 50 percent from a year ago. We think that something can be learned from this lesson.

I believe that based on the experience from States moving ahead with proposals that place common-sense restrictions on how certain products are sold, stored, and displayed can cause a significant upset in clan lab meth production. I think you should consider a Federal law that addresses these issues. You just might cause a real disruption in meth production at the small town mom-and-pop labs that are plaguing rural America.

As a drug task force commander in Indiana, I can tell you that funding that comes from the Edward Byrne Memorial Formula Grant Program is critical in helping us tackle the meth problem. I know there are proposals to change the Byrne program, but I want to strongly urge you, Mr. Chairman, to fight to preserve the focus on Byrne and on Drug Enforcement efforts. Task force operations that Byrne funds are absolutely essential and effective pieces of overall illegal drug enforcement strategies. As echoed by the National Narcotics Officers Association's Coalition and the Indiana Drug Enforcement Association, Byrne Formula grants must continue, and the focus must remain on drug enforcement activities.

Providing the means for police officers across the United States to work in multi-jurisdictional drug task forces has created thousands of drug-related intelligence leads, gang-related intelligence, and huge numbers of arrests. Neighborhoods are safer because of these efforts. In Indiana alone, we have 34 drug task forces funded by Byrne and a task force of over 200 full-time narcotics officers. State and local enforcement spends billions every year on drug enforcement, but the funding provided by Byrne is the magnet that attracts different agencies to give them incentives to cooperate.

In the meth investigations, we found that importation for methamphetamine from superlabs located outside the United States is a major problem. As local law enforcement, we fully support the

Federal anti-drug trafficking efforts of the southwest border. We also understand that California is a very significant source of meth production in huge superlabs. Because of a lot of the meth that makes its way to Indiana, we support these efforts to halt major production and trafficking activities.

Effective methamphetamine enforcement means a strong support for training and equipment, but it also means reinforcing task force cooperation throughout the Byrne program, it means robust funding for programs such as the Regional Information Sharing System [RISS] that dramatically improve cooperative efforts, and the specialized meth training provided through the program such as the Center for Drug Task Force Training. RISS is the information-sharing intelligence highway that is available to thousands of enforcement agencies across the country. This program has proven effective over many of the years and the investment as a result of the cooperation of more effective enforcement.

The State of Indiana established the Methamphetamine Abuse Task Force, of which a copy is attached to my testimony for your review. This Task Force was organized in July 2004 and represents law enforcement agencies, youth services, and family and social services.

As law enforcement officers, we are sworn to protect the citizens. As we continue to fight the growth in meth abuse and production, strong Federal support for meth enforcement, training, and equipment is absolutely critical. By now most of the people understand the meth problem, but we in law enforcement know what it takes to make real progress against it.

Thank you, Chairman Souder, for seeking our input, and I look forward to continuing to provide any guidance you and your staff needs. Thank you.

[The prepared statement of Lieutenant Colby follows:]

November 18, 2004

Congress of the Unites States
House of Representatives
Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Washington D.C. 20515-6143

Congressman:

Thank you very much, Chairman Souder, for asking me to share my views on state and local meth enforcement today. I commend you for drawing attention to the meth enforcement challenge by holding this hearing.

We are in the midst of a crisis – last year in Indiana, law enforcement seized 1,260 clandestine meth labs. The total in 2004 will almost certainly be larger. In fact, just last Friday the Indiana State Police reported to me that the state police alone have responded to 973 labs so far this year.

I can tell you that this problem – at the moment, affects rural areas more then it affects larger jurisdictions. The sky-high costs of taking down and dismantling meth labs are being carried by agencies with relatively small budgets. We have learned to be very effective at what we do, but we know we can do better if we had more resources. To get better, we need help.

Alongside the devastating physical impact of meth on abusers, the saddest aspect of the meth problem is the so-called drug-endangered children issue. Investigators in Indiana often encounter children at clan lab sites. We remove the children from immediate danger, and we work with local child protective service agencies to make sure the children are tested for the presence of meth and other toxic chemicals in their bodies. Parents who subject their kids to these toxic waste sites are held accountable through the use of child endangerment laws.

More then any other illegal drug, meth enforcement requires a high degree of training and specialization for the officers who deal with it. Many of our officers have received specialized training and equipment provided by federal agencies such as the D.E.A. This training has enabled us to more effectively seize and dismantle clan labs. We especially appreciate training on how to enter operating labs, take control of the sites, and halt production.

Let me give you an idea of the costs we have to bear in dealing with this problem. Specialized vehicle and equipment that are necessary to protect officers responding to a hazardous site are very expensive. Appropriate training absolutely essential, but it is time-consuming and expensive. Waiting for qualified clean-up companies to arrive on the scene of an active lab takes two to four hours, during which police officers who are on the payroll clock have to guard the site. They use the better part of a shift in responding to just one lab. This has a real impact on our bottom line. Hazardous material must be disposed of under strict Government regulations.

Faced with the nature of the meth problem, we cannot afford to just stand by. We have no choice but to attack the clan labs. But the costs are enormous. We are left with little choice but to appeal to our state leaders and to you in Washington to give us a hand.

Narcotics officers throughout Indiana are supporting efforts in our State Legislature to pass a bill that would require Indiana retailers to demand photo identification and a signature in a register book in order to purchase over-the-counter products that contain ephedrine and pseudoephedrine. I can tell you that we've closely watched similar efforts in the State of Oklahoma and we are aware that meth lab seizures are down by 50% from just a year ago. I think we can learn a lesson from Oklahoma's success.

I believe that, based on the experience of some states, moving ahead with proposals that place common-sense restrictions on how certain products are sold, stored or displayed can cause a significant upset in clan lab meth production. I think you should consider a federal law that addresses these issues. You just might cause a real disruption in meth production at the small "mom-and-pop" labs that are plaguing rural America.

As a drug task force commander in Indiana, I can tell you that the funding that comes from the Edward Byrne Memorial Formula Grant Program is crucial in helping us tackle the meth problem. I know there are proposals to change the Byrne program, but I want to strongly urge you, Mr. Chairman, to fight to preserve the focus of Byrne on drug enforcement efforts. The task force operations that Byrne funds are absolutely essential and effective pieces of overall illegal drug enforcement strategy. As echoed by the National Narcotics Officers Association' Coalition (N.N.O.A.C.) and the Indiana Drug Enforcement Association (I.D.E.A.), the Byrne Formula program must continue, and the focus must remain on drug enforcement activities.

Providing the means for police officers across the Unite States to work in multi-jurisdictional drug task forces has created thousands of drug-related intelligence leads, gang-related intelligence, and huge numbers of arrests. Neighborhoods are safer because of these efforts. In Indiana alone we have 34 drug task forces funded by Byrne that task over 200 full time narcotics enforcement officers. State and local law enforcement spends billions every year on drug enforcement, but the funding provided by Byrne is the magnet that attracts different agencies and gives them incentives to cooperate.

In our meth investigations we found that importation of methamphetamine from super labs located outside the United States is a major problem. As local law enforcement we fully support the federal anti-drug trafficking efforts along our Southwest border. We also understand that California is a very significant source of meth produced in huge super labs. Because of a lot of that meth makes its way to Indiana, we support efforts to halt the major production and trafficking activities there.

Effective meth enforcement means strong support for training and equipment, but it also means reinforcing task force cooperation through the Byrne program, it means robust funding for programs such as the Regional Information Sharing System (RISS) that dramatically improve cooperative efforts, and it means specialized meth training provided by program like the Center for Task Force Training (Centf). RISS is an information-sharing and intelligence "highway" that is available to thousands of law enforcement agencies across the country. These programs have proven effective over many years and the investment has resulted in more cooperation and more effective enforcement.

The State of Indiana established the Methamphetamine Abuse Task Force of which a copy is attached to my testimony for your review. This Task Force was organized in July of 2004, of representatives from law enforcement agencies, youth services, and family and social services.

As law enforcement officers we are sworn to protect our citizens. As we continue to fight the growth in meth abuse and production, strong federal support for meth enforcement, training, and equipment is absolutely critical. By now most people understand the meth problem, but we in law enforcement know what it takes to make real progress against it. Thank you Chairman Souder for seeking our input, and I look forward to continuing to provide guidance to you and your staff on this.

Respectfully Submitted,

Lieutenant George E. Colby
Division Commander/Project Director
Allen County Drug Task Force
Allen County Sheriff's Department
715 South Calhoun Street – Room #101
Fort Wayne, Indiana 46802

*Media Copy*

# STATE OF INDIANA

## METHAMPHETAMINE ABUSE TASK FORCE

## REPORT and RECOMMENDATIONS

# TABLE OF CONTENTS

**PART I.** **EXECUTIVE SUMMARY**.....1

**PART II.** **LAW ENFORCEMENT**.....3

**PART III.** **SOCIAL SERVICES**.....5

**PART IV.** **RETAILERS**.....7

**PART V.** **HAZMAT**.....9

**PART VI.** **COURTS/PROBATION**.....11

**PART VII.** **LEGISLATIVE**.....13

**PART VIII.** **ACTION PLAN**.....15

**PART IX.** **DESIRED OUTCOMES**.....16

# PART I. EXECUTIVE SUMMARY

The Second Regular Session of the 113th Indiana General Assembly enacted House Enrolled Act No. 1136. This Act established the Methamphetamine Abuse Task Force. The purpose of this Task Force was to:

1. Evaluate the problems caused by the importation and manufacture of Methamphetamine;
2. Determine the extent to which Methamphetamine affects governmental services; and
3. To develop by October 31, 2004 a long term strategic action plan to combat Methamphetamine. The objectives of this plan are the following:
   - Lessen demand for Methamphetamine;
   - Decrease the supply of Methamphetamine;
   - Improve the enforcement of Methamphetamine laws;
   - Improve the ability of agencies to deal with the social and health consequences of Methamphetamine; and
   - Improve the ability of agencies to timely and efficiently clean up hazardous materials relating to Methamphetamine.

The broadly represented Task Force held its first organizational and planning meeting in Indianapolis on July 19, 2004. Representatives from Law Enforcement Agencies, Youth Services, Family and Social Services, the Legislature and Retail Merchants gave testimony regarding how Methamphetamine impacts their respective professions and service delivery systems.

The Task Force also held public hearings in Greencastle, Knox and Vincennes to elicit local information regarding the affect of Methamphetamine on local communities.

Having reviewed the available data and information regarding the Methamphetamine problem in Indiana, the Task Force identified concepts which, not surprisingly, mirrored a similar study conducted by the federal government's Methamphetamine Interagency Task Force in its January 2000 Report. The Indiana Methamphetamine Abuse Task Force concurs as to the relevance of their findings to the Indiana experience adding additional points.

- Methamphetamine is a dangerous, addictive drug and the population of users is not well defined and is expanding.
- There is a lack of data about the prevalence of Methamphetamine use and abuse.
- There is no single source country or single specific trafficking route for Methamphetamine entering into the state.
- The clandestine laboratories where Methamphetamine is produced domestically pose significant hazards to law enforcement officials; nearby residents; and through environmental hazards, the general public.

- Methamphetamine is destructive to the human body, affecting neurological, behavioral and psychological functioning long after use has stopped.
- The precursor chemicals used to produce Methamphetamine are relatively inexpensive, widely available, easy to transport and difficult to regulate.
- Episodes of violent behavior have been associated with Methamphetamine use.
- There is a general lack of public understanding about Methamphetamine, including its risks and consequences, requiring public education efforts.
- Information for treatment providers on effective strategies has not been disseminated as widely as necessary and has not been disseminated effectively to all of the various providers involved with Methamphetamine abusers.
- Methamphetamine abuse in rural and suburban areas presents a challenge for treatment providers in terms of resources and training.
- There is a lack of standardized protocols for protecting children exposed to Methamphetamine and dangerous drug lab chemicals.
- Standardized clean-up/decontamination protocols of illegal drug laboratory sites have not been established.
- There is a lack of standardized drug laboratory notification procedures insuring local Health Department and Protective Service Agencies awareness.

The Task Force includes in this document relevant and particular impact findings as well as recommendations. A conservative estimate as to the economic cost of Methamphetamine to the citizens of Indiana is at least $100 million per year not taking into account the human toll of lost resources, family abuse and child neglect.

Realizing the threat Methamphetamine poses to our communities, the Task Force has also developed and included in this report an action plan that it recommends for adoption and implementation as well as desired outcomes.

# PART II. LAW ENFORCEMENT

## A. OVERVIEW

Law enforcement agencies play a pivotal and front line role in dealing with the Methamphetamine problem. As this drug infiltrates into our communities, police agencies with limited budgets are forced to adjust priorities and reduce important and more traditional public safety activities.

## B. IMPACT FINDINGS

1. The number of Methamphetamine cases submitted to the Indiana State Police Crime Laboratories has grown from 1,106 cases in 1999 to a projected 3,206 cases in 2004 representing an increase of nearly 200% resulting in evidence backlogs.

2. The number of drug laboratories seized in Indiana increased from 177 in 1999 to a projected 1,500 labs in 2004 representing a 750% increase at an annual cost of more than $4,500,000.00.

3. Drug laboratory related arrests by the Indiana State Police increased from 456 arrests in 2001 to 961 in 2003 amounting to a 100% increase in just two years.

4. Indiana State Police have seized and dismantled drug laboratories in all but one county in the state.

5. Precursor and other drug laboratory related chemicals are available and are accessible in quantity throughout the state.

6. Of the 84 individuals currently incarcerated in the Orange County Jail, 72 or 85% are charged with Methamphetamine related crimes.

7. Of the 85 inmates currently in the Vermillion County Jail, 60 or 70% are charged with Methamphetamine related crimes.

8. Of the 302 inmates currently in the Vigo County Jail, 257 or 85% are charged with Methamphetamine related crimes.

9. The jail budget for the Vigo County increased from $812,000.00 in 1998 to $3,500,000.00 in 2004 representing more than a 300% increase due in large measure to Methamphetamine.

10. Forty-five percent (45%) of the current inmate population in the Starke County Jail are charged with Methamphetamine related crimes.

11. Law enforcement lacks an integrated intelligence network for sharing Methamphetamine and drug laboratory related information.

12. Law enforcement lacks sufficient networking with retailers, health, protective services and environmental management agencies.

13. Crime laboratory services lack sufficient staffing and retention to keep up with demand for services for Methamphetamine related analysis.

14. Not all law enforcement agencies have sufficient training and equipment to effectively and safely address the Methamphetamine and drug laboratory problem.

15. Domestic enforcement costs four times as much as treatment for a given amount of user reduction, seven times as much for consumption reduction and fifteen times as much for societal cost reduction.

## C. RECOMMENDATIONS

1. Seek additional funding to increase enforcement activities in terms of interdiction, prioritized drug laboratory investigations and crime laboratory staffing.

2. Reduce availability and accessibility of precursors and other drug laboratory related chemicals through legislation and forming partnerships with retailers, merchants and communities through a statewide *Methamphetamine Watch Program.*

3. Implement effective security measures such as locks, fencing, theft tagging and increased law enforcement surveillance to reduce the theft of anhydrous ammonia.

4. Explore the effectiveness of the anhydrous ammonia additives such as *Glo-Tell* and *Ferrocene.*

5. Continue to provide statewide, Methamphetamine awareness training to law enforcement agencies as well as mandating it at the Indiana Law Enforcement Academy.

6. Establish Regional Task Forces with the emphasis being the sharing of information regarding Methamphetamine.

7. Require law enforcement agencies to notify local health, protective services and environmental management agencies of identified drug lab locations.

8. Established a statewide accessible intelligence clearing house for Methamphetamine related information.

9. Determine through laboratory analysis the possible source of origin for Methamphetamine samples to prioritize investigations.

10. Promote aggressive charging, bonding and prosecutions of violations related to Methamphetamine statutes.

# PART III. SOCIAL SERVICES

## A. OVERVIEW

Methamphetamine threatens governmental services, communities and families. It is therefore critically important to develop a "social" strategy to deal with this epidemic. An effective strategy must include prevention, treatment, rehabilitation and protective service components.

## B. IMPACT FINDINGS

1. Drug abuse emergency room visits involving Methamphetamine grew nationally 54% between 1995 and 2002.

2. Methamphetamine related treatment admissions in Indiana grew over 100% from 2000 to 2003.

3. In Indiana the number of known drug laboratory affected children rose from 12 in 2000 to 208 in 2003.

4. In Knox County Methamphetamine related family preservation costs rose from $171,000.00 in 1999 to $389,140.00 projected in 2004 an increase of a 120%.

5. In Knox County the number of Children in Need of Supervision or Services (CHINS) filings related to Methamphetamine rose from 20 in 1999 to a projected 84 in 2004 an increase of more than 300%.

6. Effective treatment programs cost on average $6,000.00 to $8,000.00 as compared to incarceration costs of approximately $20,000.00 per year.

7. Indiana lacks a formalized protocol for the handling, evaluation and treatment of children exposed to hazardous chemicals at drug laboratory sites.

8. Many of our citizens lack health insurance coverage for the cost of drug abuse treatment.

9. There is a lack of in-depth and persistent Methamphetamine awareness training programs in our schools and communities.

10. In general, Indiana health care providers lack a standardized, proven and cost effective treatment program for Methamphetamine addiction.

11. Use and manufacture of Methamphetamine in the home results in child abuse and neglect.

## C. RECOMMENDATIONS

1. Establish statewide formal guidelines for the handling, treatment and reporting of drug endangered children.

2. Make mandatory the notification to Family Social Services Administration of the removal of children from homes that are exposed to Methamphetamine laboratories.

3. Encourage health insurance companies to provide parity for drug and alcohol treatment services.

4. Develop effective and proven Methamphetamine abuse treatment guidelines.

5. Increase the Methamphetamine abuse treatment capacity in the community and in correctional facilities.

6. Provide effective outreach services to individuals in need of treatment.

7. Develop an effective Methamphetamine educational program for our schools that include teachers and students as well as communities.

8. Construct a Methamphetamine Awareness website to provide information to various government and community groups.

# PART IV. RETAILERS

## A. OVERVIEW

Unlike most other drugs, Methamphetamine brings with it the hazards and dangers associated with its illegal and clandestine manufacture. Many of the precursors and chemicals have legitimate and practical household uses and are therefore readily available. Retailers handling their products must play an active role in the partnership to solving the Methamphetamine problem.

## B. IMPACT FINDINGS

1. Precursors and chemicals related to the manufacture of Methamphetamine are readily available and accessible throughout the state.

2. Retailers on a continuing basis are reporting thefts of Methamphetamine related precursors and chemicals.

3. There is a lack of awareness on the part of many retailers in recognizing suspicious purchase and theft activities indicative of drug laboratory activity.

4. There is a lack of security around sources of anhydrous ammonia preventing the theft of this product by drug laboratory operators.

5. Agricultural retailers estimate that the costs associated with the theft of anhydrous ammonia in Indiana exceeds $5 million per year.

6. There is a lack of partnerships between law enforcement and retailers in sharing Methamphetamine related information.

7. There is a lack of statutorial immunity for retailers who report suspicious activities to law enforcement agencies.

8. The state lacks a statewide formal *Methamphetamine Watch Program.*

## C. RECOMMENDATIONS

1. Control the availability and accessibility of Pseudoephedrine and Ephedrine containing products.

2. Establish a statewide *Methamphetamine Watch Program.*

3. Control availability and accessibility of drug laboratory related precursors and chemicals.

4. Flag products that can be used for the production of Methamphetamine through UPC.

5. Identify patterns and practices of Methamphetamine cooks and users as they relate to retailers.

6. Provide Methamphetamine abuse patterns and practices information to retailers throughout the state.

7. Encourage the reporting of suspicious purchase activities to law enforcement agencies.

8. Implement effective security measures such as locks, fencing and theft tagging to reduce the theft of anhydrous ammonia.

9. If useful, employ the use of chemical additives to anhydrous ammonia tanks such as *Glo-Tell* or *Ferrocene.*

10. Encourage the reporting of thefts and tampering of anhydrous ammonia tanks to law enforcement agencies.

11. Provide statutory immunity to retailers reporting suspicious drug lab related activities.

# PART V. HAZMAT

## A. OVERVIEW

As the number illegal drug laboratories increase the impact on our environment worsens. Found in houses, apartments, trailers, cars, motels, and our out-of-doors, these sites become contaminated with hazardous chemical waste.

## B. IMPACT FINDINGS

1. The extent to which our environment is being affected is not known.
2. Illegal drug laboratories are found in houses, apartments, trailers, motels, vehicles and the out-of-doors.
3. The long term health effects of exposures to drug laboratory related chemicals are not fully understood.
4. Many property owners are victims of this chemical contamination.
5. Individuals charged with manufacturing Methamphetamine rarely have sufficient funds to pay for the clean-up.
6. The cost of bulk chemical removal of illegal drug laboratories processed by the Indiana State Police alone exceeds $4,500,000.00 per year.
7. The cost and protocols for decontamination of a drug laboratory site is not well defined.
8. Clean-up standards and guidelines for drug laboratories are not well defined.
9. Procedures for health department and environmental management agencies notification of drug laboratory sites are not in place.
10. Hazmat agencies need additional and continual training on the topic of illegal drug laboratories.

## C. RECOMMENDATIONS

1. Conduct a study to determine the effect illegal drug laboratory activity has on the environment in Indiana.

2. Determine the long term health threat that exposure to drug laboratory chemicals have on our citizens.

3. Seek continued federal assistance in providing clean-up funding.

4. Develop standards, guidelines and responsibilities for the decontamination of drug laboratory sites.

5. Develop a notification protocol for notifying local health departments and hazmat agencies as to the discovery and location of illegal drug laboratories.

6. Increase the amount of drug laboratory awareness training to hazmat personnel.

# PART VI. COURTS/PROBATION

## A. OVERVIEW

Courts and probation departments throughout the state see increasing numbers of individuals charged with Methamphetamine related offenses. In many jurisdictions Methamphetamine related offenses represent the bulk of their casework. Increases in Methamphetamine arrests and charging significantly tax the resources of many of our courts and probation departments.

## B. IMPACT FINDINGS

1. Methamphetamine related charges statewide rose from 1,689 in 2000 to 6,466 in 2003 nearly a 300% increase.

2. In Knox County Superior Court 1 there were ten Methamphetamine related charges in 1999. In 2004, 216 Methamphetamine related filings are projected representing a 2,000% increase.

3. The Department of Correction reports that in the year 2000, 2,883 individuals were incarcerated for Cocaine/Methamphetamine related violations which grew to 3,872 in 2004 representing a 34% increase.

4. The annual cost to house an inmate in the Department of Correction is approximately $20,000.00.

5. The total cost to house convicted drug related offenders in the Department of Correction is approximately $78 million annually.

6. Courts and probation departments need more drug laboratory awareness training to better protect themselves from dangerous offenders and chemicals.

7. Many jurisdictions lack sufficient resources for establishing drug court programs.

## C. RECOMMENDATIONS

1. Reduce Methamphetamine related court costs by reducing recidivism by implementing mandatory, treatment based, sentencing programs.

2. Direct low risk, non-violent drug offenders to mandatory treatment in lieu of incarceration.

3. Seek additional funding resources to increase the number of available drug treatment courts.

4. Establish a uniform and effective treatment program with follow-up mandatory drug screening for individuals on probation for Methamphetamine related offenses.

5. Encourage and support public awareness training regarding Methamphetamine issues designed to reduce and deter its use.

6. Encourage prosecutors to seek higher bonds in Methamphetamine related violations.

7. Encourage cooperation between probation departments and law enforcement agencies in identifying Methamphetamine related violations.

# PART VII. LEGISLATIVE

## A. OVERVIEW

A primary function of a government is the protection of its citizens. Legislative activities should include initiatives that reduce the use and availability of Methamphetamine and the chemicals used to make it. This product is medically harmful and addictive to our citizens. The chemicals used in making Methamphetamine are also dangerous and a threat to public safety.

## B. IMPACT FINDINGS

1. Precursor substances used to make Methamphetamine are readily available and accessible.
2. Chemical reagents used to make Methamphetamine are readily available and accessible.
3. Anhydrous ammonia tanks are not typically sufficiently locked or secured.
4. There are no statutory requirements for the handling, treatment and reporting of drug endangered children.
5. There are no statutory requirements for the notification of local health departments and hazmat agencies as to the presence and location of illegal drug laboratories.
6. There are no statutory requirements or guidelines for the decontamination of illegal drug laboratory sites.
7. I.C. 35-48-4-14.5 1.b complicates the analysis of Pseudoephedrine containing materials.
8. There are not enough drug treatment courts available throughout the state.
9. Legislators lack sufficient awareness and understanding on the Methamphetamine and illegal drug laboratory problems.

## C. RECOMMENDATIONS

1. Enact legislation restricting the accessibility of Pseudoephedrine and Ephedrine containing products.

2. Enact legislation restricting the availability of Pseudoephedrine, Ephedrine and Phenylpropanolamine containing products by limiting the quantity that can be purchased in a given period of time.

3. Enact legislation requiring the uniform handling, treatment and reporting of drug endangered children.

4. Enact legislation requiring the uniform reporting of drug laboratory sites to local health departments, hazmat agencies and the Indiana State Police.

5. Enact legislation requiring the appropriate remediation of contaminated drug laboratory sites.

6. Amend I.C. 35-48-4-14.5 1.b to read *"10 grams of Ephedrine or Pseudophedrine pure or adulterated"*.

7. Enact legislation creating more drug treatment courts.

8. Provide Methamphetamine and illegal drug laboratory awareness programs to members of the Indiana General Assembly.

## PART VIII. ACTION PLAN

1. Enact legislation that controls the accessibility and availability of Pseudoephedrine, and Ephedrine containing products by requiring retailers to:

   a) Store such products behind the counter in the pharmacy;
   b) Require purchasers to provide valid photo identification;
   c) Require purchaser to sign for such products; and
   d) Limit the quantity of these products that may be purchased over a defined period of time.

   This legislation should also provide statutory immunity to retailers who provide suspicious product purchase information to law enforcement agencies.

2. Implement a *Methamphetamine Watch Program* statewide.

3. Enact legislation adopting standard protocols, responsibilities and requirements that address the treatment and processing of drug endangered children.

4. Enact legislation adopting standard protocols, responsibilities and requirements for the chemical and/or biological decontamination of clandestine laboratory sites.

5. Develop and implement effective Methamphetamine Awareness training for our schools and communities.

6. Develop effective and proven Methamphetamine abuse treatment guidelines with expanded delivery capacity to our communities and correctional facilities.

## PART IX. DESIRED OUTCOMES

1. Reduction of the use of Methamphetamine.
2. Reduction of the manufacture of Methamphetamine.
3. Reduction of the overall availability of Methamphetamine.
4. Increased public awareness of the dangers associated with Methamphetamine.
5. Decreased theft of chemical products used to manufacture Methamphetamine.
6. Decreased number of child abuse and neglect cases related to Methamphetamine.
7. Decreased chemical contamination of our environment due to illegal Methamphetamine laboratories.
8. Increased public safety.

Mr. SOUDER. Thank you.

As we tackle this difficult issue, as we have done in a couple of other hearings, it is important we hear what impact it has on others as well. Not everybody, in fact a very small percent, who use pseudoephedrine are in fact drug addicts. And our first witness in this group is Mr. Joseph Heerens, Senior Vice President of Government Affairs for Marsh Supermarkets, on behalf of the Food Marketing Institute, another Hoosier, and representing a Hoosier firm that is a long-time family grocery business that has expanded across the State of Indiana.

Mr. HEERENS. Mr. Chairman and members of the subcommittee, I am Joseph R. Heerens. I am the Senior Vice President of Government Affairs for Marsh Supermarkets, headquartered in Indianapolis, IN. My statement today is on behalf of Marsh Supermarkets and the Food Marketing Institute.

To effectively combat the illegal diversion of chemical precursors, we need a comprehensive strategy and partnership between law enforcement, our regulatory agencies, manufacturers, and the retail community. But we have serious concerns about imposing stringent controls on precursor chemicals at the retail level. I am specifically referring to the Oklahoma law that relegates cough and cold products to Schedule V status.

Under the Oklahoma model, only stores that have a pharmacy department are allowed to sell these products, and these products must be kept behind the pharmacy counter. For our industry, a Schedule V approach is very troublesome. That is because an overwhelming majority of grocery stores in the United States do not have a pharmacy department. For example, my company currently operates approximately 120 supermarkets in Indiana and Ohio, but only 46 of them have a pharmacy department.

Therefore, under the Oklahoma model, more than 60 percent of our stores could not sell pseudoephedrine products that our customers expect us to carry to meet their shopping needs. At the national level, 79 percent of grocery stores do not have an in-store pharmacy. In other words, four out of every five grocery stores in the United States would be taken, in large part, out of the cough and cold business.

Of our 46 stores with pharmacy departments, store hours are quite different from hours of operation in the pharmacy department. Most of our stores are open 24 hours to serve our customers who shop at all hours of the day and night. In comparison, our pharmacy departments are typically open less than 12 hours on weekdays and less than 8 hours on weekends. Therefore, even if the store is open for business, if the pharmacy department is closed or if the pharmacist is not on duty, sales of cough and cold products would not be permitted and our customers would have to shop elsewhere to meet their needs in this respect. This causes us great concern.

A Schedule V approach would also present a number of operational challenges for pharmacy departments in grocery stores. For example, the average Marsh Supermarket typically carries on its retail shelves more than 150 types of cough and cold products. If we have to keep these products behind the pharmacy counter, my company would likely have to reduce the number of these products

to no more than a few dozen. This is due to space limitations in the existing pharmacy departments. As such, Schedule V classification would mean less choice for our customers, as well as dramatically reduced customer access.

It is also likely that Schedule V would force my company to spend a lot of money on construction to reconfigure our store layouts to make the pharmacy departments larger in order to facilitate new work flow and to accommodate the relocation and placement of these products behind the pharmacy counter.

Additionally, Schedule V restrictions raise quality-of-care issues for our pharmacy operations. Under Schedule V, only the pharmacist or the pharmacy technician would be permitted to sell these products, which means less time for them to carry out their primary professional duties of preparing and dispensing prescriptions and consulting with customers about the safe and effective use of their prescription medications.

Schedule V poses problems for supermarket companies and their customers who have a legitimate need for these products in order to treat their coughs and colds. There would be reduced customer access and customer inconvenience because their local grocery store, which they shop more than two times each week, would not be allowed to sell these products, or, if it contained a pharmacy department, would be allowed to sell these products, but only behind the pharmacy counter.

Schedule V may also mean higher prices because sales will be restricted and the pharmacist would be required to ask for photo ID and have the customer sign a written log.

Finally, Schedule V could not come at a more inopportune time, with the current flu vaccine shortages here in the United States.

The supermarket industry applauds the work of the law enforcement community in its efforts against methamphetamine, but we do not believe Schedule V is the right solution. Instead, we advocate for a more comprehensive approach for reducing methamphetamine production, trafficking, and abuse.

In this regard, the supermarket industry strongly supports the following initiatives: first, elimination of the blister pack exemption; second, a national uniformity threshold sales limit of six grams; third, greater regulatory authority, controls, tracking and quota limits over imports and the sale of bulk chemicals of ephedrine and pseudoephedrine; fourth, a ban on Internet sales of precursor chemicals; fifth, promotion and funding of educational training programs for store employees concerning suspicious pseudoephedrine purchases (i.e., the Meth Watch program); sixth, stiffer penalties for the manufacturing, distribution, and possession of methamphetamine; and, seventh, greater Federal regulatory authority, including licensing and inspection at the distributor level, especially secondary wholesalers.

Mr. Chairman, this concludes my statement, and thank you for allowing me to participate in this important hearing.

[The prepared statement of Mr. Heerens follows:]

**TESTIMONY**

**JOSEPH R. HERRENS**

**SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS**

**MARSH SUPERMARKETS, INC.**

**BEFORE**

**HOUSE GOVERNMENT REFORM**

**SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY & HUMAN RESOURCES**

**THURSDAY, NOVEMBER 18, 2004**

**"LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE"**

## INTRODUCTION

Good morning Mr. Chairman and Members of the Subcommittee on Criminal Justice, Drug Policy and Human Resources. My name is Joseph R. Heerens and I am Senior Vice President of Government Affairs for Marsh Supermarkets, Inc., headquartered in Indianapolis, Indiana. My statement today is on behalf of Marsh Supermarkets and the Food Marketing Institute ("FMI"). FMI is our national trade association representing food retailers and wholesalers.

First of all, I wish to commend Chairman Souder for your leadership on the methamphetamine problem and for your efforts to establish an improved federal policy that will help combat the diversion of pseudoephedrine products. This leadership is reflected in legislation (H. R. 5347) that Chairman Souder recently introduced which would eliminate the so-called safe-harbor exemption for cough and cold products that contain pseudoephedrine and would establish a national threshold limitation of 6 grams for single transactions at the retail level. Marsh Supermarkets and FMI strongly support your proposal.

## SCHEDULE V – THE OKLAHOMA MODEL

Our industry fully understands the magnitude of the methamphetamine problem in the United States, and we also recognize the fact that legitimate cough and cold products are used to manufacture methamphetamine. To effectively combat the illegal diversion of chemical precursors, we need a comprehensive strategy and partnership between law enforcement, our regulatory agencies, manufacturers and the retail community.

But, we have serious concerns and misgivings about recent initiatives at the state level that impose stringent controls on precursor chemicals. I am referring specifically to the Oklahoma law that relegates cough and cold products to Schedule V status. Under the Oklahoma model, only retail stores that have a pharmacy department are allowed to sell these medications, and these items must be kept behind the pharmacy counter.

## SUPERMARKET CONCERNS

For our industry, a Schedule V approach is very troublesome. That's because an overwhelming majority of grocery stores in the United States do not have a pharmacy department. For example, my company currently operates approximately 120 supermarkets in Indiana and Ohio, but only 46 of them have a pharmacy department. Therefore, under the Oklahoma model, more than 60 percent of our stores could not sell the pseudoephedrine products that our customers expect us to carry to meet their shopping needs. In terms of Indiana, there are approximately 851 supermarkets throughout the state, but only 182 of these stores - 21.4 percent – have a pharmacy

department. In the Third Congressional District, there are 105 supermarkets doing business, but only 23 – 22.1 percent – have an in-store pharmacy.

Of our 46 Marsh Supermarkets that do have a pharmacy department, store hours are quite different from hours of operation in the pharmacy department. Most of our supermarkets are open 24-hours to serve our customers, who shop at all hours of the day and night. In comparison, our pharmacy departments are typically open less than 12 hours per day; those hours being from 9:00 am to 9:00 pm on weekdays, 9:00 am to 7:00 pm on Saturdays, and ll:00 am to 5:00 pm on Sundays. Therefore, even if the store is open for business, if the pharmacy department is not open or if the pharmacist is not on duty, sales of cough and cold products would not be permitted and our customers would have to shop elsewhere to meet their needs in this respect. That causes us great concern.

## OPERATIONAL ISSUES

A Schedule V approach would also present a series of operational challenges for pharmacy departments in grocery stores. For example, the average Marsh Supermarket typically carries, on its retail shelves, more than 150 types of cough and cold products that contain pseudoephedrine. In contrast, under a Schedule V approach requiring cough and cold medications to be kept behind the pharmacy counter, my company would likely have to reduce the number of these products to no more than a few dozen. This is due to space limitations in the existing pharmacy departments. As such, a Schedule V classification would mean less choice for our customers as well as dramatically reduced customer access to these over-the-counter medications. Moreover, consumers would no longer have the opportunity to physically examine and read the labels of the different brands and types of cough and cold products prior to making a purchasing decision.

It is also likely that Schedule V would force my company to spend a lot of money on construction to reconfigure our store lay-outs to make the pharmacy departments larger in order to facilitate new work flow and to accommodate the relocation and placement of all these products behind the pharmacy counter.

Additionally, Schedule V restrictions raise significant quality-of-care questions for our pharmacy operations. Under Schedule V, only the pharmacist or the pharmacy technician would be permitted to complete a sales transaction with a customer, which means less time for them to carry out their primary professional responsibilities of preparing and dispensing prescription drugs and consulting with customers about the safe and effective use of their prescription medications.

## IMPACT ON CONSUMERS

For all of the reasons I have mentioned, the supermarket industry cannot support a Schedule V classification for cough and cold products containing pseudoephedrine. Schedule V poses problems for supermarket companies and their customers who have a

legitimate need for these products in order to treat their coughs and colds. There would be reduced customer access and customer inconvenience because their local grocery store, which they visit more than two (2) times each week, would not be allowed to sell these products or, if it contained a pharmacy department, would be allowed to sell these products but only behind the pharmacy counter.

We further suspect that Schedule V may mean higher prices, as these over-the-counter products move from self-service to behind the pharmacy counter where the pharmacist will be required to ask for photo identification and have the customer sign a written log. And finally, Schedule V could not come at a more inopportune time with the current flu vaccine shortages here in the United States.

Our industry applauds the hard work of the law enforcement community in its efforts against methamphetamine, but we do not believe Schedule V is the right solution. Instead, we advocate for a more comprehensive approach to the meth problem in terms of reducing methamphetamine production, trafficking and abuse.

## ALTERNATIVE INITIATIVES

In this regard, the supermarket industry strongly supports the following initiatives:

- Elimination of the blister pack exemption
- A national uniformity threshold sales limit of 6 grams
- Greater regulatory authority, controls, tracking and quota limits over imports and the sale of bulk chemicals of ephedrine and pseudoephedrine
- A ban on Internet sales of precursor chemicals
- Promotion and funding of educational training programs for store employees concerning suspicious pseudoephedrine purchases (Meth Watch Program).
- Stiffer penalties for the manufacturing, distribution and possession of methamphetamine
- Greater federal regulatory authority, including licensing and inspection at the distributor level, especially secondary wholesalers

Mr. Chairman, this concludes my statement, and thank you for allowing me to participate in this important hearing.

Mr. SOUDER. Thank you very much.

Our next witness is Dr. Linda Suydam, president of the Consumer Healthcare Products Association. Thank you for coming today.

Ms. SUYDAM. Thank you. Chairman Souder and Ranking Member Cummings, thank you for the opportunity to testify before the subcommittee today.

I am Linda Suydam. I am president of the Consumer Healthcare Products Association, a 123-year-old trade association representing the manufacturers of over-the-counter medicines and nutritional supplements.

Methamphetamine is a serious problem that plagues entire communities. And as we have heard in earlier testimony today, pseudoephedrine is a necessary ingredient in its manufacture.

CHPA is deeply concerned that safe and effective medicines that are purchased by millions of consumers each year to treat symptoms of colds, allergies, asthma, and the flu are being diverted to manufacture meth in small clandestine labs. We are committed to the need for strong action to prevent the diversion of these important medicines to the illegal manufacture of methamphetamine.

According to the DEA, these small clandestine labs account for about 20 percent of the meth supply in this country. Yet, that small number causes significant problems for communities. We believe, however, that the only way to significantly address the meth production and abuse is through a multifaceted approach that empowers communities to deal with all aspects of the problem.

We encourage tough comprehensive measures to attack the meth problem at every level of its manufacture and abuse, including limiting the number of packages a consumer can purchase at one time; enacting severe penalties for those manufacturing and selling meth, especially those endangering children; strengthening law enforcement resources and providing them with the tools to take action against the major traffickers who fuel the meth supply and, as well, the meth cooks who threaten the safety of communities; and we need more programs focusing on prevention and education like Meth Watch.

Mr. Chairman, we know you support Meth Watch, and we applaud the introduction of your bill, which would authorize Federal funding for this effective program. Implementation of Meth Watch has resulted in a dramatic reduction in theft of products used to make meth. It is now established in nine States, and more are on the way.

Comprehensive efforts are working in other States facing this epidemic. According to EPIC data, meth lab busts have decreased since 2001 in Washington, Oregon, and Kansas, all of which have Meth Watch programs in place. And California has seen a dramatic reduction in labs due to an aggressive system of tracking and monitoring of meth precursors, mandatory registration of wholesalers and distributors, retail sales restrictions, and aggressive law enforcement and prosecution. These proven approaches should be adopted by all 50 States.

At the Federal level, we need to put more resources into stopping the demand for methamphetamine and stopping meth from coming into this country. The ONDCP recently issued a plan to address

meth. CHPA applauds the administration for the development of that plan, and we agree with many of its recommendations.

All of these efforts are encouraging and will help reduce the meth problem in our communities. It is imperative that we work together toward achieving the same goal. Some, however, are now calling for a different approach. They propose to make pseudoephedrine a Schedule V drug. At first glance, putting these medications behind the counter might sound sensible, but before we embrace a single-step approach that ignores the totality of this abuse problem, and restricts access for consumers who need these medicines, we need to make sure that it is truly an effective solution. We believe it is not.

Like everyone who has testified here today, I believe that any decrease in meth lab busts is commendable. The OBN lab numbers are important if they continue to go down, but the Oklahoma law has only been in effect for a few months, and there are conflicting statistics that indicate it is too early to draw sweeping conclusions. Compared with the concrete data that indicates significant lab reductions in Kansas, Washington, Oregon, and California, it begs the question on the effectiveness of the Oklahoma approach and the long-term effectiveness on reducing meth use in general.

Over-the-counter medicines remain important to our healthcare system. A recent study by Northwestern University concluded that OTC cough and cold medicines saves the U.S. economy and our healthcare system almost $5 billion a year. Furthermore, OTC medicines serve a critical public health need, a fact that will likely be drawn into sharp focus given the flu vaccine shortage this year.

In conclusion, Mr. Chairman, as great as it might sound, there is no quick fix to this complex problem. We must take a comprehensive approach that works, not half measures that have a greater impact on sick kids, caregivers, and flu sufferers than on criminals. We must all work together with all the resources that are available to us. We look forward to working with you and continuing our efforts to fight methamphetamine at every level. Thank you.

[The prepared statement of Ms. Suydam follows:]

Testimony of

**LINDA A. SUYDAM**
**PRESIDENT**
**CONSUMER HEALTHCARE PRODUCTS ASSOCIATION**

**UNITED STATE HOUSE OF REPRESENTATIVES**
**COMMITTEE ON GOVERNMENT REFORM**
**SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOUCES**

Presented on November 18, 2004

Chairman Souder and Members of the Subcommittee:

Good morning and thank you for the opportunity to testify before the subcommittee today. I am Linda Suydam, president of the Consumer Healthcare Products Association (CHPA), a 123-year-old trade association representing the manufacturers of over-the-counter (OTC) medicines and nutritional supplements.

Methamphetamine is a serious problem that plagues entire communities, and as explained in testimony today, pseudoephedrine is a necessary ingredient in its manufacture. Approved by the U.S. Food and Drug Administration for over-the-counter use, pseudoephedrine is a nasal decongestant and is sold as either a single-ingredient product or in combination cough/cold products.

CHPA is deeply concerned that safe and effective medicines manufactured by its member companies and purchased by millions of consumers each year to treat symptoms of colds, allergies, asthma, and the flu are being diverted to manufacture meth in small clandestine labs. We understand the scope of this problem, and are committed to the need for strong action to prevent the diversion of these important medicines to the illegal manufacturing of methamphetamine.

According to the U.S. Drug Enforcement Administration (DEA), these small, clandestine labs account for about 20 percent of the meth supply in this country. And while that may be a small amount considering the entire scope of the methamphetamine problem, it concerns us greatly. We know that the process used to make meth is extremely toxic; destructive; expensive to clean-up; and damaging to all those present, especially children.

We also are concerned with the majority of the meth supply coming into this country as a finished drug or being produced in large super labs and the lack of resources being allocated to address that problem. We understand the far-reaching consequences of the methamphetamine problem in this country, and feel that the only way to significantly

address meth production and abuse is through a multi-faceted approach that empowers communities to work towards a common goal.

We encourage tough, comprehensive measures to attack this problem at every level of its manufacture and use, including limiting the number of packages a consumer can purchase at a time. We need to enact severe penalties for those manufacturing and selling meth, especially those endangering children with illicit activities. We need to strengthen law enforcement resources and provide them with the tools to take action against the major traffickers who fuel the meth supply and the meth cooks who threaten the safety of communities. And we need more programs focusing on prevention and education, like Meth Watch.

Mr. Chairman, we know that you support Meth Watch, and we applaud the introduction of your bill, HR 5345. This bill would authorize $5 million in federal funding for Meth Watch grants to states. As you know, implementation of Meth Watch has resulted in dramatic reductions in the theft of products used to make meth. Meth Watch success stems from community involvement: it involves the whole community – law enforcement, retailers, business leaders, and citizens – in education and prevention efforts, and appears to be having an impact on actual meth usage. Meth Watch is now established in nine states and more are on the way.

Comprehensive efforts are proving to work in other states facing this epidemic. According to the El Paso Intelligence Center's data, meth lab busts have decreased since 2001 in Washington, Oregon, and Kansas – all of which have Meth Watch programs in place. Additionally, California has seen a dramatic reduction in labs due to an aggressive system of tracking and monitoring meth precursors, mandatory registration of wholesalers and distributors, retail sales restrictions, and aggressive law enforcement and prosecutions.

At the federal level, we need to put more resources into stopping the demand for methamphetamine and reducing the amount of meth coming into this country. The Office of National Drug Control Policy (ONDCP) recently issued the National Synthetic Drugs Action Plan, which is the federal government's response to the production, trafficking, and abuse of synthetic drugs and diverted pharmaceutical products. CHPA applauds the Administration for the development of this plan, and we agree with many of the recommendations contained therein.

In particular, CHPA looks forward to working with DEA on legislation and regulations to tighten controls and enhance the tracking of bulk precursor chemicals, such as pseudoephedrine, that are imported into the United States. For many years, there has been a significant discrepancy between the amount of pseudoephedrine reported by DEA as imported into the United States and what is used by CHPA member companies. Since DEA has been unable to identify where all the pseudoephedrine brought into this country ends up, we urge this subcommittee to use its oversight authority to determine whether DEA already has authority to track pseudoephedrine imports and what additional measures by our industry might be helpful. CHPA also welcomes the opportunity to

work with DEA, FDA, and the U.S. Centers for Disease Control and Prevention to determine what amount of pseudoephedrine serves the legitimate medical needs of the U.S. population. This effort would assist DEA in determining if there are any unusual or unnecessary upward spikes in the importation of this important OTC ingredient. CHPA also supports the removal of the federal blister pack exemption if it is tied to a national, uniform retail sales threshold.

CHPA commends the DEA and the Department of Justice for their plans to focus resources on reducing the illicit sales of pseudoephedrine over the Internet and on developing a multimedia education campaign to reduce the demand and use of methamphetamine. CHPA has been urging ONDCP and Congress to allocate some of the money available for the Youth Anti-Drug Media Campaign to this end. To date, very little of this money has been used for meth prevention. Methamphetamine has been called one of the most addictive drugs on the street. We need to stop our kids from trying meth in the first place and put programs in place that focus on demand reduction and treatment.

All of these efforts are encouraging, and I believe, will help reduce the meth problem in our communities. It is imperative that we work together towards achieving this same goal. However, some are now calling for a different approach. They propose to make pseudoephedrine a "Schedule V" drug, restricting sales only to drugstores with a pharmacy, placing them behind the pharmacy counter, only to be sold by a pharmacist or pharmacy technician. At first blush, putting these medications behind the counter to frustrate criminals might sound sensible. Before we embrace a single-step approach that ignores the totality of this substance abuse problem and restricts access by consumers who need these medications, we need to make sure it is a truly effective solution. We believe it is not.

Inconvenience aside, putting these medications behind the counter would have a significant effect on consumers. If your pharmacy closes at 6:00 p.m. on a Saturday and your child comes down with a cold and can't sleep after closing hours, you may be out of luck until Monday. And consumers living in rural areas without access to a local pharmacy will not have access to these medicines at all.

In Oklahoma, where pseudoephedrine has been put behind pharmacy counters, state officials are touting statistics that show a decrease in the number of lab busts. That's an important number if it continues, but the law has only been in effect for a few months and conflicting statistics indicate that it is too early to draw conclusive lessons from that state's approach. The Oklahoma State Bureau of Investigation reported an increase in meth labs in June 2004. At the same time, there's contradictory evidence the problem is getting worse: reports show more drug smuggling and more meth-related crime.

Like everyone who testified at today's hearing, I believe that any decrease in meth lab busts is commendable. But given the wide range of statistics reported from Oklahoma, compared with the concrete data that indicates significant reductions in Kansas, Washington, Oregon, and California, the effectiveness of the Oklahoma

approach and its long-term effectiveness on the reducing meth use in general is very much in question.

OTC medications serve a critical public health need. For example, they provide a safety net for those with limited access to other forms of healthcare, including the tens of millions of uninsured Americans. They provide a convenient and cost-efficient form of healthcare, for example every dollar spent on OTCs yields almost $2.50 in healthcare benefits. This is even more critically important to America's seniors who constitute a seventh of the population but use a quarter of the OTC medicines.

Pseudoephedrine-containing products are a critical part of the OTC cough/cold category, and the evidence builds for cost-effectiveness here, as well. Recently, Northwestern University researchers concluded that OTC cough/cold medications save the economy and the health system almost 5 billion dollars a year. Instead of sitting in a doctor's waiting room for hours, in minutes a parent can visit a drugstore or grocery store and purchase a trusted and safe medicine that has been available to consumers without a prescription for decades to treat coughs, colds and allergies. Given the severe shortage of the flu vaccine this year, these medications will turn out to be more important to our healthcare system than ever before

As great as it might sound, there is no "quick fix" to this complex problem. We must take comprehensive steps that work, not half-measures that have a greater impact on sick kids, care givers and flu sufferers than on criminals. We must all work together with all the resources available to us. We look forward to working with you and continuing our efforts to fight methamphetamine at every level. Thank you.

Mr. SOUDER. Thank you very much.

Our cleanup witness, so to speak, would be Ms. Mary Ann Wagner, vice president of the Pharmacy Regulatory Affairs, National Association of Chain Drug Stores.

Ms. WAGNER. Good morning, Chairman Souder and Ranking Member Cummings. My name is Mary Ann Wagner, and I am Vice President of Pharmacy Regulatory Affairs at NACDS. I am a pharmacist licensed in the State of Indiana. I think I am the third Hoosier up here on the panel. I served as a member of the Indiana Board of Pharmacy from 1988 to 1996.

NACDS commends Chairman Souder for his leadership in addressing the methamphetamine problem. We appreciate the opportunity to testify today before this committee as you examine ways the Federal Government can assist law enforcement in the fight against methamphetamine.

Our membership consists of more than 200 chain community pharmacy companies operating over 33,000 pharmacies. Collectively, chain pharmacy comprises the largest component of pharmacy practice, with over 100,000 pharmacists. Our pharmacies fill over 70 percent of the 3 billion prescriptions dispensed annually in the United States.

Our membership is deeply concerned about the problems of methamphetamine production and abuse. We have ongoing calls and meetings to discuss this issue and to develop solutions to this devastating problem in our country. The majority of our members have taken voluntary proactive steps that go beyond what is required by their State laws to reduce the theft and illegitimate use of pseudoephedrine products. Among other things, they have initiated voluntary sales limits of these products, participate in voluntary education and theft deterrent programs like Meth Watch, train their employees on methamphetamine abuse, and work with law enforcement by reporting suspicious activity in their stores.

We want to continue to work with DEA and law enforcement to reduce the illicit meth production in the United States, but we also want to balance those efforts with our ability to provide access to OTC products for legitimate consumers and to optimize the skills of pharmacists and the pharmacy staff that our members employ.

The new Oklahoma law is not only operationally difficult for our members to comply with, but we also have some very serious concerns as to why the law appears to be reducing the clandestine labs in the State, when in fact the same results could be accomplished without the extreme measures that were taken in Oklahoma. Since other States are now looking to Oklahoma and Schedule V as the model, we appreciate the opportunity to State our reasons why we question the effectiveness of the Oklahoma law and oppose making pseudoephedrine a Schedule V controlled substance.

First, we have found no reliable statistics or data to support the statements that the law has been successful or is the optimal approach. For this reason, we are pursuing independent verification of the anecdotal statistics that appear to point to a reduction in methamphetamine labs.

Second, under the law in Oklahoma, those who have been arrested for methamphetamine-related crimes must appear before a magistrate, judge, or court, who are likely to deny bond. Had this

law been in effect a year ago, the addict who killed the State trooper there would have been behind bars, rather than back on the streets to commit a senseless killing.

Third, we are concerned about the effect that classifying pseudoephedrine as a Schedule V controlled substance would have on the practice of pharmacy and the services that we provide. Requiring pharmacists to perform the duties of a sales clerk would not be an efficient use of their time, training, or knowledge. Time spent tracking cold medicine sales is time not spent practicing pharmacy.

We believe that any benefits achieved under the Oklahoma law could be replicated in other States without the unnecessary burdens of Schedule V requirements. Registration of non-pharmacy retailers who sell pseudoephedrine products would drastically reduce the caseloads of product being sold at the back doors of rogue convenient stores and gas stations.

Raising barriers for consumers to access pseudoephedrine products is a short-term solution to a long-term problem. The methamphetamine problem in this country goes beyond toxic lab investigation and cleanup. And we don't mean to minimize the seriousness of the problems these labs pose for law enforcement and the communities affected; however, we must also pursue long-term solutions to the methamphetamine problem that reduce the demand for illicit substances.

So, in conclusion, if the Federal Government is serious about reducing the methamphetamine problem, we would recommend a number of opportunities be explored, some of which are: stiff penalties for those arrested or convicted of methamphetamine-related offenses; encouraging States to register non-pharmacy retailers that sell pseudoephedrine products; significantly increasing funding for methamphetamine abuse, prevention, and treatment programs; working with the State Department and officials in chemical-producing countries to more closely track every sale of pseudoephedrine into the United States; providing incentives for drug companies to develop an effective decongestant that cannot be converted into methamphetamine; providing more funding and resources to DEA for enforcement activities and to local law enforcement for lab cleanup.

Mr. Chairman, this concludes my testimony. We thank you for the opportunity to participate in this hearing, and we look forward to working with all present today to find effective solutions to the methamphetamine problem. We look forward to sharing with you the research and data that we are pursuing in the hope of providing further evidence to help us develop meaningful solutions for addressing these problems.

[The prepared statement of Ms. Wagner follows:]

# STATEMENT ON "LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE"

SUBMITTED TO
HOUSE GOVERNMENT REFORM
SUBCOMMITTEE ON CRIMINAL
JUSTICE, DRUG POLICY AND HUMAN
RESOURCES

U.S. HOUSE OF REPRESENTATIVES

NOVEMBER 18, 2004

NATIONAL ASSOCIATION OF CHAIN DRUG STORES
(NACDS)
413 N. LEE ST.
ALEXANDRIA, VA 22314
703-549-3001
www.nacds.org

NACDS appreciates the leadership of Chairman Souder in vigorously investigating the meth issue and pursuing a role for the federal government to assist with the efforts to stop methamphetamine addiction. We welcome the opportunity to testify before the House Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources about law enforcement and the fight against methamphetamine.

Our membership consists of more than 200 chain community pharmacy companies operating over 33,000 community pharmacies. Collectively, chain community pharmacy comprises the largest component of pharmacy practice, with over 100,000 pharmacists. Our pharmacies fill over 70 percent of the 3 billion prescriptions dispensed annually in the United States.

Our membership is deeply concerned about the problems of methamphetamine production and abuse. NACDS continues to have ongoing calls and meetings to discuss this issue and to develop solutions to this devastating problem in our country. The majority of the chain community pharmacy industry has taken voluntary, proactive steps that go beyond what is required by law to reduce the theft and illegitimate use of pseudoephedrine products. They:

- have initiated voluntary sales limits of these products,
- participate in voluntary education and theft-deterrent programs such as Meth Watch,
- voluntarily eliminate consumer self-access to pseudoephedrine products in their stores in geographic areas where methamphetamine is a problem,
- participate in youth anti-methamphetamine education efforts,
- educate their employees about methamphetamine abuse to raise awareness and prevent questionable sales of these products, and
- work with law enforcement by reporting suspicious activity in their stores.

Chain pharmacy has worked closely with DEA and state and local law enforcement officials since 1995 to stem the tide of methamphetamine production in communities across the U.S. Our Retail Alert Network, an electronic system for reporting robberies of

controlled substances, is the result of partnering with DEA to develop a program to reduce the number of robberies in community pharmacies. The Retail Alert Network can be expanded to include the reporting of OTC thefts, including pseudoephedrine.

NACDS pledges to continue working to find effective methods to prevent diversion while, at the same time, balancing the need for American consumers to access approved pseudoephedrine products to treat colds, allergies and sinus infections.

**Introduction**

Oklahoma officials have stated that the recently passed Oklahoma House Bill 2176 ("Trooper Nik Green Act") has dramatically reduced methamphetamine labs in Oklahoma in the past few months. We are pleased that it appears that Oklahoma may have found a short-term solution to the methamphetamine problem. However, we are guarded in our optimism at this point.

Methamphetamine production and abuse are issues that raise strong emotions. In fact, the "Trooper Nik Green Act" was passed in Oklahoma, riding on a swell of emotion that appears to be on the verge of spreading across the country. Thus far, however, there exist no reliable statistics or data that the "Trooper Nik Green Act" has been successful or is the optimal approach. For this reason, NACDS is pursuing independent verification of the anecdotal statistics that appear to point to a reduction in methamphetamine labs. First, we have surveyed our member pharmacies in Oklahoma to learn more about the impact of the new law on their operations. Second, we have recently contacted research organizations to conduct an independent study of the statewide impact of the "Trooper Nik Green Act." In the meantime, we would like to provide our initial thoughts on why the "Trooper Nik Green Act" appears to be reducing the number of methamphetamine labs in Oklahoma.

When the "Trooper Nik Green Act" is mentioned, it is often referred to as the Act that made pseudoephedrine a Schedule V controlled substance. We believe that the touted lab reduction has resulted from other provisions of the Act, and not necessarily because of

the provision that schedules pseudoephedrine as a class V controlled substance. We believe that our analysis will assist the federal government in providing law enforcement with a targeted solution to the methamphetamine problem that will also not unduly burden law-abiding consumers and retailers.

**Necessary Restrictions and Penalties upon Those Arrested for and/or Convicted of Methamphetamine-Related Offenses**

Under the "Trooper Nik Green Act," those who have been arrested for methamphetamine related crimes must appear before a magistrate, judge, or court, who are likely to deny bond. According to the Oklahoma Department of Public Safety, before the passage of the Act, "many addicts were posting bond to then immediately consume more of the drug."[1] The "Trooper Nik Green Act" was named for a state trooper that had been killed by a methamphetamine addict. "The addict accused of murdering Trooper Nik Green was arrested twice in the 30 days prior to the slaying for possessing methamphetamine."[2] Clearly, prior to the enactment of the "Trooper Nik Green Act," Oklahoma law enforcement did not have the necessary legal tools to keep methamphetamine addicts from harming the residents of Oklahoma. NACDS encourages states to impose necessary restrictions and penalties upon those arrested for and/or convicted of methamphetamine-related offenses. Undoubtedly, these enhanced law enforcement provisions are an important reason why the Oklahoma law appears to be working.

We believe the federal government could further assist by encouraging other states to pass similar restrictions and penalties upon those arrested for and/or convicted of methamphetamine-related offenses. Additionally, the government should consider making methamphetamine-related offenses federal offenses.

---

[1] Press Release from Oklahoma Governor: *Governor Henry Urges Other States to Adopt Versions of Oklahoma Law Combating Meth;* September 29, 2004, Quoting Oklahoma Department of Public Safety Commissioner Kevin Ward.

[2] Ibid.

**The Pseudoephedrine "Gray Market" is Eliminated**

Since the "Trooper Nik Green Act" prohibits anyone other than pharmacists or pharmacy technicians from selling pseudoephedrine products, the law has essentially shut down the "gray market" for these products. Both Oklahoma and DEA officials acknowledge that pseudoephedrine products were sold *by the caseload* out of the back doors of rogue convenience stores and gas stations, and by owners of self-storage lockers. Classifying pseudoephedrine as a Schedule V controlled substance has eliminated this problem in Oklahoma because only licensed pharmacies may now sell these products. The state now knows who sells these products; they are not being sold by questionable establishments. *The supply to rogue businesses has been shut down.*

The benefits achieved under the "Trooper Nik Green Act" can be replicated elsewhere without the unnecessary burdens of Schedule V requirements. To do this, retailers that wish to sell pseudoephedrine products would be required to register with the proper state agency, with the exception of licensed pharmacies, which would already fall under the jurisdiction of the state board of pharmacy. All retailers that sell pseudoephedrine products would be subject to the control of the state agency. Shady operators would be reluctant to register, which would subject them to possible inspection.

We believe that requiring non-pharmacy retailers to register with a state agency would assist law enforcement by shutting down rogue pseudoephedrine retailers and consequently shut down the gray market for pseudoephedrine.

**Pharmacists are Highly-Trained Professionals**

We are concerned, however, about the effect that classifying pseudoephedrine as a Schedule V controlled substance would have on the practice of pharmacy. Classifying pseudoephedrine as a Schedule V controlled substance requires that it be tracked and sold by pharmacists.[3] Pharmacists are highly-trained professionals; the entry level degree for pharmacists is a six-year doctorate. These doctors of pharmacy (Pharm.D.'s) are too

[3] The "Trooper Nik Green Act" makes an exception to allow technicians to sell pseudoephedrine.

valuable to be relegated to the status of "cold medicine gatekeepers," a duty that requires barely more training or knowledge than clerks who sell cigarettes or alcohol.

As we know, pharmacists are vital members of the health care delivery team. Pharmacists do more than just fill orders, they ensure that medications are taken and used properly; they counsel patients on drug therapy; and they check for drug interactions, allergies and other adverse reactions. Physicians and patients rely on pharmacists for their drug expertise. Requiring pharmacists to perform the duties of a sales clerk would not be an efficient use of their time, training, and knowledge. Time spent tracking cold medicine sales is time not spent practicing pharmacy.

**Reducing Access is a Short-Lived Solution**

If indeed the "Trooper Nik Green Act" has reduced the methamphetamine problem in Oklahoma, we fear that this effect may be short-lived. Experience with the drug abuse problem has shown that the problem is not eliminated by merely erecting barriers to the drug supply. To eliminate drug abuse, we must also focus resources on drug abuse prevention and treatment; we must eliminate the demand for drugs. So long as people are addicted to drugs, they will find ways to get them. In fact, Oklahoma officials admit that the "Trooper Nik Green Act" has done nothing to stop methamphetamine from coming into Oklahoma from criminals based in Mexico and the Southwest United States.

We believe that the federal government can further assist law enforcement by providing more funding and resources for methamphetamine abuse prevention and treatment. This would reduce the demand for methamphetamine, which would have long-lasting benefits.

**The "*Oregonian* Study"**

We would also like to comment on a widely-distributed recent study on the methamphetamine problem recently published in the Portland, Oregon newspaper *The Oregonian.* Oregon, like many other states, has had an increase in toxic meth labs. While DEA has indicated that some of the facts presented in *The Oregonian's* study may

be outdated and incomplete, we believe that *The Oregonian* provided viable solutions that would have little negative effect on consumers and relatively low cost to taxpayers.

First, *The Oregonian* suggests that U.S. diplomats should "work with officials in India, China, the Czech Republic and Germany to more closely track every sale of pseudoephedrine from the few factories that produce it."[4] In response, DEA claims that it does not have the legal authority to demand the necessary shipment information from sources in Europe, India and China.[5] Moreover, DEA admits that there exists a very large discrepancy between U.S. pseudoephedrine import records and the records of legitimate U.S. manufacturers of pseudoephedrine-based products. No one is sure where the unaccounted pseudoephedrine goes—most likely into criminal hands. We recommend that the federal government work more closely with the State Department to provide DEA with the necessary treaties and other legal requirements so that DEA may effectively track pseudoephedrine sales from sources in Europe, India, and China. "[Second,] The National Institute on Drug Abuse, which spends $1 billion a year on addiction research, [might be encouraged to] dedicate [financial resources] to developing an effective decongestant that cannot be converted into meth. Pfizer, one of the leading sellers of cold medicine in the United States, holds the patent to such a medicine. It has never been brought to market, Pfizer says, because it was not enough of an improvement as a cold medicine to make it commercially viable. The government might work to provide incentives for drug companies to create such a product, just as it already subsidizes research on unprofitable 'orphan drugs' that promise cures for rare diseases."[6]

Finally, the DEA should consider devoting more resources to enforcement activities that would prevent the diversion of pseudoephedrine. "The agency spends $700 million annually eradicating coca plants in South America."[7] It devotes only $140 million to tracking and investigating the flow of pseudoephedrine and ephedrine.[8]

---

[4] "Unnecessary Epidemic," *The Oregonian,* October 3, 2004.
[5] Letter to Robert J. Caldwell, Editorial Page Director, *The Oregonian;* from Karen P. Tandy, Administrator, Drug Enforcement Administration; November 3, 2004; Page 2.
[6] "Unnecessary Epidemic," *The Oregonian,* October 3, 2004.
[7] Ibid.
[8] Letter to Robert J. Caldwell, Editorial Page Director, *The Oregonian;* from Karen P. Tandy, Administrator, Drug Enforcement Administration; November 3, 2004; Page 1.

**Conclusion**

Clearly, if the federal government is serious about reducing the methamphetamine problem in the U.S., NACDS would recommend serious consideration of the following demonstrable efforts:

- Encourage states to pass necessary restrictions and penalties upon those arrested for and/or convicted of methamphetamine-related offenses;
- Federalize methamphetamine-related offenses;
- Encourage states to license non-pharmacy retailers that sell pseudoephedrine products;
- Significantly increase funding for methamphetamine abuse prevention programs;
- Work in concert with the State Department and officials in chemical producing countries (e.g., India, China, the Czech Republic and Germany) to more closely track every sale of pseudoephedrine into the United States;
- Provide incentives for drug companies to develop an effective decongestant that cannot be converted into methamphetamine;
- Provide more funding and resources to DEA for enforcement activities;
- Enact import controls on bulk pseudoephedrine and ephedrine similar to Schedule II controlled substances; and limiting imports to those necessary for legitimate commercial needs;
- Provide funding resources to local law enforcement for methamphetamine lab cleanup;
- Provide additional funding for treatment of methamphetamine addicts so that they can eventually become productive members of our communities; and
- Continue to coordinate with Canada and Mexico on distribution tracking and control of pseudoephedrine and ephedrine.

Mr. Chairman, on behalf of NACDS, I want to thank you very much for enabling us to come before your subcommittee to share both our concern about the problem of methamphetamine production and abuse as well as our interests and efforts to work at both the federal and state and local levels of government to significantly reduce the diversion of pseudoephedrine products. We look forward to sharing with you the

research and data we are pursuing in the hope of providing further evidence to help us understand ways by which we can address these problems.

Mr. SOUDER. First, I want to thank everybody for their testimony, and since this is narcotics enforcement, and arguably one of the hottest debates that is occurring at the State and Federal level, it is really helpful to have all of you on the same panel. Too often we have disconnects; we hear something on one side and hear something on the other side, and you go to one place and go that sounds really good, and you go somewhere else and that sounds really good. This gives us a chance for a little extended discussion.

I have some other questions beyond this for this panel, but let me plunge right into this.

Mr. Wright, clearly, you heard these discussions in Oklahoma as you went through the law. There were a whole range of concerns, from pharmacy hours and the impact on the grocery store to pharmacists being professionals. Let me just stick with those for a start here.

Did you look at treating this more like cigarettes, where it would be behind the counter, but not have to be a pharmacy, and somebody might have to show a license and be limited in the quantity they buy, as opposed to treating it as a Schedule V and putting it in a pharmacy?

Mr. WRIGHT. Yes, sir, that was discussed, but not seriously considered. We already have an industry and an institution in Oklahoma, that is the pharmacy, where we regulate drugs. All drugs and pharmacies are regulated by government because of some sort of need. We thought that pseudoephedrine belonged in a pharmacy.

Mr. SOUDER. Did you hear, when you were developing the law, the concerns from the grocery stores and from the pharmacists, as well as the pharmaceutical companies?

Mr. WRIGHT. No, sir, we didn't hear so much from the retailers in Oklahoma. Initially they were a little bit concerned, but we had a number of instances where independent convenient store operators were making as much as $70,000 in a 6-month period, when they made $5,000 selling Coca Cola products. Some of those stores are clearly making an awful lot of money selling pseudoephedrine to methamphetamine addicts. We don't regulate those people, and it appeared to us to be very difficult to do that.

Mr. SOUDER. Mr. Heerens, compared to a small one-person convenient store or grocery store, your firm would be huge; compared to some other supermarket chains, you are small. In looking at the challenge here, we heard from a representative at the hearing in Hawaii that was very concerned because there they have lots of small towns and, by definition, every pharmacy and grocery store is small; they don't even have scanners.

At the same time, in Indiana, one of the problems we see with pseudoephedrine and ephedrine precursors, we have even seen at least one case in my district of somebody getting a pharmacy license predominantly to be able to deal with biker gangs; and that much of like what we see and just heard about Oklahoma is coming from a lot of wherever they see a vulnerability, they will go and hit that store.

How do you respond, specifically, to what Mr. Wright said, that in fact it is undeniable that there are certain places where they are loading up?

Mr. HEERENS. No, there is no question it is a serious problem, and Indiana does have a problem like many States. We had, this summer, in July 2004, the creation of the Meth Abuse Task Force, which is making recommendations to the Indiana General Assembly, many of the recommendations that have been discussed at this table today. But I think, as you have heard, I know I was encouraged to hear what Sheriff Bundy had to say because he said that the retail community in his State was very cooperative.

As we have become familiar, especially over the last year, of a serious problem in Indiana, our community, the retail community is stepping up and trying to be a part of the solution, and one of the things we have been talking about an organization in Indiana called the Indiana Retail Council, which is a trade organization for retailers—we talked about this actually last month, as well as earlier this week—is what can we do to try to have a positive impact; and you have heard some of the things that we have outlined: elimination of the blister pack, limiting the amount of products to six grams, maybe stronger sentencing. Those are some of the things that we think will make a difference here, constructive, positive steps, but not drastic steps that may not be warranted.

But in terms of rural areas, in terms of specific pockets of problems, I am not sure. In the State of Indiana, as you know, it is mostly an agricultural State with few large cities. In terms of dealing with pockets or I think you talked about a license in the biker gangs, I am not sure what the solution to that is except enforcement of the law once that becomes known and putting those kind of people out of business. And then in Indiana one of the things that I think is coming is, again, a limitation on the amount that you can buy, two or three products per transaction, as well as elimination of the blister pack and some other things.

Mr. SOUDER. I think you also have in your recommendations with wholesalers?

Mr. HEERENS. Yes.

Mr. SOUDER. How do you see that? Rather than ask you that question, Mr. Wright, do you believe this problem could be addressed by wholesalers looking at unusual quantities going out of proportion, like the person that said they were selling more than Coca Cola? How much of an auditing problem is that?

Mr. WRIGHT. That is a tremendous problem for us when it is widespread, and it apparently is. And also I might add that I don't think three-pack-per limits work. We have that self-imposed by Walmart in Oklahoma. We have videotape after videotape where people get out of a car, four or five of them, they all go buy three packs, they go back to the car, they go buy three more packs, they come back, they go to some other Walmart, they are doing the same thing. We really work just trying to keep pseudoephedrine out of the manufacturers' hands, and we don't think that is a viable solution.

Mr. SOUDER. Can they do that through a Schedule V drug by going to different pharmacies?

Mr. WRIGHT. Right now they can, but when we implement our Statewide computer system that will authorize those threshold limits, they won't be able to do that. And as we speak, pharmacies in small communities particularly are networking with each other and

showing their log books to law enforcement or comparing names to see who is presently trying to purchase more than the nine gram limits, so we are making some arrests already.

Mr. SOUDER. Have you seen anything move to internet?

Mr. WRIGHT. No, I have not.

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. I am so glad that we had both. I agree with the chairman. I was feeling pretty good about you for a while there, Mr. Wright. Then these folks came along and it just was a clash, because I can see both sides of the issue. So when I look at Mr. Heerens' recommendations, I was trying to figure out what can we do to try to, at the same time, maintain the convenience for customers for you, Ms. Wagner and you, Ms. Suydam, but at the same time deal with the problem.

And as I was listening to all of you, I can understand why you all may have had the success that you had in getting this passed, and not so much opposition. Part of it is what Mr. Heerens said, that is, that they are figuring out what happened and they see the effect.

The other part of it is that probably the problem was so overwhelming in your jurisdiction that people said, well, we don't care about the convenience, we would rather deal with the problem. I am just guessing. But now we are at a point where, in some kind of way, we are trying to find a solution to this problem. We usually don't have this kind of exchange, so I have to take advantage of it.

You have heard the arguments here. What is your response to that? You understand what they are saying.

Mr. WRIGHT. Yes, sir.

Mr. CUMMINGS. And it is reasonable. Do you agree?

Mr. WRIGHT. I don't think that it is.

Mr. CUMMINGS. You don't think it is reasonable?

Mr. WRIGHT. No, sir.

Mr. CUMMINGS. OK, why don't you go ahead?

Mr. WRIGHT. I have been a policeman for 25 years. I go back into those phenylacetic acid laboratories. I have seen the carnage associated with the abuse of methamphetamine, and you clearly understand it. What we are really weighing here is treating the sniffles versus solving this problem, in my opinion. As a police officer, personally speaking, I would rather solve the problem at minor inconvenience to people with nasal congestion. I think it is a very good trade. The people of Oklahoma seem to think so.

Mr. CUMMINGS. Sheriff Bundy, the Meth Watch program, as I listened to you, I just tried to think like these manufacturers think. First of all, they understand that it is truly a thin blue line. And if a person is a manufacturer knowing there is a thin blue line, and it is even thinner in rural areas, it seems as if they would say to themselves, well, this is a situation where we probably have more of an opportunity to get away with it. I am not saying that is true, but that is what they may conclude.

Mr. BUNDY. It is true. That fact is just really enhanced by the truth that we don't have 24-hour police patrol; we are abutted by more urban areas. Rural counties are attractive to these individuals for all those very reasons, and the honest answer is, yes, more

often than not they are able to come to rural areas of America and get away with it.

Mr. CUMMINGS. And then when I hear you go into a small lab for 9 hours, the overwhelming nature of that on a small police force has to be just absolutely devastating. We are all reasonable people, and I am just trying to figure you all listened to Mr. Heerens—I don't know why I can't pronounce your name.

Mr. HEERENS. Nobody can.

Mr. CUMMINGS. Oh, OK, good. I feel better now.

You heard his suggestions and you heard Ms. Wagner and Dr. Suydam, and I understand what you said, Officer Wright, and I respect that. I support police officers. I really do, because I know how important your job is. So how do we now, with all of this, come up with—I mean, you heard the suggestions.

I mean, what is reasonable? What do you all suggest we do, hearing everything that you have heard, I mean from my police side? Because these arguments are going to be made, I can tell you; I can hear them. They were, by the way, extremely well done, both sides extremely well done. We have two major problems, and I guess it all depends on who is observing.

One may feel like one problem is worse than the other and far outweighs the other, so we have a certain solution; then there is the other side. So where is the middle? What do you see that we could do to try to meet all of your hopes and dreams that we deal with this problem, but at the same time not inconvenience folks to the degree that it might be unreasonable?

I know where you stand, Mr. Wright.

Sheriff.

Mr. BUNDY. I believe there are a lot of pieces that have to come together, and I think there can be some very productive partnerships formed from law enforcement, from retailers, to communities. I think everybody is coming to a greater appreciation of the scope of this problem, and we recognize it as being a true problem.

And the Oklahoma approach is working for Oklahoma; it may work other places. Something of a smaller scale may work other places. I don't know the answer any better than you do, I guess, or anyone here at the panel, but it is my belief and my experience after all these years, and just the countless cases, there is going to have to be a partnership that involves the community and law enforcement and retailers that all play a big role in this comes together to formulate a workable solution that we can all be happy with.

Mr. SOUDER. Just for the record, I come from a small town of 700, but it is in a big county. The smallest county I represent is about 40,000 people. You said your county had 10,000 in it total?

Mr. BUNDY. Yes, sir.

Mr. SOUDER. Is it a somewhat unique situation in a sense? Do you have much mobility in and out of the county? I mean, do you pretty much know everybody in the county?

Mr. BUNDY. Yes.

Mr. SOUDER. So it becomes a little bit easier challenge to work with a grocery store or a pharmacy where you know everybody. Is that fair to say?

Mr. BUNDY. That is the tremendous strength in programs such as Meth Watch, yes. A long time ago I remember, early in my career, a sheriff from Wichita, which is our urban area in Kansas, talking about how the best way to really solve problems starts just like that, it is a neighbor-to-neighbor thing and then it is a block-to-block thing, and then it goes from community-to-community to encompass the county was the story he related.

And that is very much how it does work and that is my experience, that I have to sell the neighborhoods on it, then they sell the blocks, and then the blocks the communities, the communities the counties, and the counties the States, and right up the chain to where we really come up with some tremendous solutions. But that is the grassroots approach I take with problems. In this instance it has proven to be really effective in trying to manage our methamphetamine problem.

Mr. CUMMINGS. You know, Mr. Chairman, I am a lawyer, and before I came here I practiced for about 19 years in a small practice, but the way most people got caught in criminal situations is somebody told on them, or else they told on themselves. And I was just thinking we have to maximize that cooperation. I guess the Meth Watch program aims at doing that. And I was thinking about the drug-free communities piece. Maybe we need to look at that and see.

I just have to go back and look at it, whether there are things that we can do to enhance that to help some of this prevention and addressing these community needs, because we have to, sheriff, going back to what you just said, we almost have to try to do everything in our power to do this almost by community by community. And perhaps having the drug stores and others who may sell these products help us in any way that they can to try to address this problem.

You know, Martin Luther King, Jr. said you cannot lead where you do not go, and you cannot teach what you don't know. That is why I appreciate what the law enforcement side said so much, because I know that when you see the carnage, when you see the jails filled, it is like this is what you have to deal with everyday. And I guess after you have seen it, Sheriff Bundy, for 20 years plus, and then you see generation after generation, you say, well, I've got to do—and I don't want you to give up.

And I am just imaging somebody sitting right now, watching this on C–SPAN and saying, OK, let us go and do this, because there is this thin blue line. So I just think we have to figure out a way. We in the Congress have to just try to figure out how we can empower communities more and at the same time try to bring folks together, both the retailers and others who may have a problem with some of these solutions, and you all so that we can lift our whole communities up, because we can't just sit here. I am not saying that we are not doing things, because we have already heard the testimony, but I just can't believe that we can't do more. So I just don't believe it.

So anybody may want to comment, and then I will be finished.

Ms. WAGNER. You are absolutely right, we need to do more. Two of the suggestions that we made I think are something that could be done quite easily and would make a difference. One is limiting

or eliminating the blister pack rule as it stands today, and starting sales limits within retail stores. But even more than that, limiting the number of stores that carry the products. Right now all pharmacies are licensed by their State board of pharmacy. They know who those pharmacies are, they go out, they regularly inspect them. When it comes to selling this particular product, we find it in convenience stores, in gas stations, and that is where some of the real problems are happening.

We don't necessarily believe in limiting stores that can carry it, but at least if they are not licensed by the board of pharmacy, let them register so that some entity in the State knows who is selling it and can go and inspect those premises, look at their invoices, look at their records. Right now there is no one body overseeing the non-pharmacy retailers, and that is something that could be done quite easily, quite quickly, and it would at least give us more knowledge of where these problems are occurring.

Mr. CUMMINGS. Does that hurt you, Mr. Heerens?

Mr. HEERENS. I don't believe it does. I happen to think that is probably a good idea.

Mr. CUMMINGS. So that still would allow Marsh to—you said a large percentage of your stores don't have a pharmacy.

Mr. HEERENS. Right.

Mr. CUMMINGS. So products that would fall under that category, in your suggestion, they would have to still register because they don't have a pharmacy. And the ones that have a pharmacy, they are already regulated.

Ms. WAGNER. Given the opportunity to register. But I would imagine that the rogue operators aren't going to do that. They do not want regulators knowing who they are and that they are selling caseloads out the back door. So this would legitimize those retailers who carry the product. They could still have it available for legitimate customers, but at least an entity in the State would know who and where these people are that are selling it.

Mr. CUMMINGS. Well, I just want to again thank all of you for what you are doing. This is a major problem. It is one of the reasons why I agreed to do this subcommittee, because I see the pain of drugs everyday. We don't have the methamphetamine problem in Baltimore too much, where I am from, but no matter what the drug is, it is just so painful to see how people are destroyed. So we are going to do the best we can. We want to work with you.

Mr. Chairman, I hope that we can revisit, a year from now, Oklahoma's situation. And one of the things, too, that I saw as a problem, and you alluded to it, Sheriff Bundy, is that when you have an Oklahoma law, then does that force people into the next State or surrounding States?

Therefore, what would happen is you would almost have to have a national law, because then people just move from State to State to State, and then possibly an adjoining State gets a bigger problem. I don't know, I am not sure about the answers to that, but I know that in almost everything else, just like most States, when they look at something like cigarette tax and things of that nature, they worry about those things because they force people into another State.

So I think those are the things that we have to consider. And the fact is that there is a role for the Federal Government to play. We want to play our role, but we also want to be supportive of our States and our locals. So we will give it the best we can, and we just thank you all very much.

Mr. SOUDER. Thank you.

Dr. Suydam, do you agree with eliminating the blister pack? Food Marketing said they did, the Association of Chain Drug Stores. What is your association position?

Dr. SUYDAM. Yes, we agree with that as well. In fact, I agree with all of the points that Ms. Wagner made and Mr. Heerens. We believe that registration will be an important factor in limiting sales to the legitimate groceries and to the legitimate pharmacies, and will get rid of these rogue places where the product is going out the back door.

But, you know, one other thing we haven't mentioned, Mr. Chairman, and I know this is a law enforcement hearing, but I do think we have to focus on prevention as well. And I think we have done some work with the Partnership for Drug-Free America that looks at how do you raise awareness about the problem of methamphetamine addiction and, in fact how you can raise awareness with parents and with pediatricians and children, to get people to stop using this, because we have heard from all the law enforcement people how addictive this drug is and how you cannot, in many cases, be treated because there is not an effective treatment.

So we think a major effort needs to be in the prevention area as well. But we also agree that we need to enforce the law; we need to strengthen our laws, and we need to make the other retail restrictions that we have talked about and registration.

Mr. SOUDER. I want to comment just briefly on what you said, because probably 60 percent, at least, of our work is with narcotics, so we have lots of different things, even segment further the meth in future hearings. But I want to touch briefly on the prevention side. I talked to Director Walters just last Friday about this very subject, about using some of the ad campaign on meth, but here is our fundamental problem: there is no meth addict who didn't start with marijuana, period. We have had multiple testimony around the country about poly drug use and other things. But if we don't get hold of the marijuana problem, we don't tackle the meth problem. And everybody likes to talk about meth, but they don't want to talk about marijuana.

The fact is that our National Ad Campaign, combined with other efforts, have reduced marijuana use in the United States the last 2 years in a row. So guess what Congress is about to do in its infinite wisdom, and to my great frustration? And the problem is the "other body" as we say here. They are reducing the National Ad Campaign. We have consistently reduced it now for 3 straight years. Ranking Member Cummings and myself, along with Speaker Hastert, have worked, and Chairman Istook has held a higher number in the House, but we are battling to keep that program alive.

The Partnership for Drug-Free America does a great job, but without some of this National Ad Campaign funding, if we further divide a limited amount of dollars in basic advertising, which you

all know in your industries, if you go below a certain threshold, you might as well not do the program, because there is not enough repetitions and enough penetration of the market. So if we segment this by drugs, we will lose the momentum we have in one and not get the other one started. And I am exasperated, and I hope the Speaker succeeds here in the next 48 hours of getting this dollar amount back up, or we are in big trouble in our No. 1 prevention program.

Our second big prevention program, Safe and Drug-Free Schools, has been so watered down in so many districts. They use it for any after-school program because maybe it will make the kids think that they are not going to get involved, and it was supposed to be an anti-drug program.

So when we actually talk about prevention programs in the United States, we don't have many. Partnership for Drug-Free America is a great program, the community drug coalitions are, but we have reduced the thrust of what we have been doing at this, in spite of this committee's efforts to highlight it.

Now, I have a couple of other specific questions. I wondered, Mr. Wright, what was your reaction to the licensing of a lot of these smaller operations? Would they go out if they were monitored more closely, and would that give us another way to handle it?

Mr. WRIGHT. I don't really know the answer to that. What we looked at is we already have a body where we keep drugs that need to be protected, and that is the pharmacy. It might be worth exploring.

Mr. SOUDER. So you basically knocked out convenience stores and anybody else from being able to sell the type of products you described if they didn't have a pharmacy.

Mr. WRIGHT. Yes. That still left liquid gel caps and liquid preparations in the convenience stores. Those are products that we don't see in methamphetamine laboratories.

Mr. SOUDER. This is a huge question, and we are talking about meth today, but we had a hearing in Orlando on OxyContin and oxycodones; similar argument, similar debate. As DEA consistently reports, the No. 1 cause of drug deaths in the United States is legal drugs, and that there is continuing pressure to try to figure out how to get hold of this. We have this rash of OxyContin. We picked up the main guy or group in my area on OxyContin. In Orlando it went through one high school and killed 10 kids, just like that. How do you balance that with pain relief? These are huge questions, not just in the meth precursors.

I want to make sure I get on the record here, Lieuenant Colby, because we got mostly on this subject, but this hearing is also dealing with a broader range. Byrne Grants are proposed to be cut, and I don't believe at the end of the day they will be cut. Could you describe what would happen if Byrne Grants were cut, as it relates to you? And I would be interested in hearing the other law enforcement say that too.

Lieutenant COLBY. Certainly. As I said in my statement, we have 34 drug task force grants in the State of Indiana that are multijurisdictional. This is one of the requirements through the Indiana Criminal Justice Institute that sends out the Byrne moneys. One

of the problems is one-third of the narcotics officers in the State of Indiana will be unemployed if the Byrne Grants go away.

I am personally from a large county of Allen County. We have 350,000 people in our county. My unit is seven people. It is our responsibility. Plus, I picked up Huntington County, Huntington City, and two other counties that work with us on knocking off meth labs and so on. We don't get involved in their meth labs as much as they take care of that and we try to help them take care of their cocaine and crack head problem. So it is kind of a tit-for-tat thing. Their funds are getting eaten up because of it. I try to help them out, out of the drug task force funds.

So the Byrne Grants are doing a multi thing in everybody's area, and the Indiana Drug Enforcement Officers Association is saying one of the problems we have with meth is, as officers, as all of you know, law enforcement officers really don't see a lot of gray, it is black or white, and you either go to jail or you don't. And I think that is one of the stances that Oklahoma took. It is not a patch, it is a fix, and they are getting results; and it is not tomorrow or a year from now, it is today. And I think that is one of the big problems that you are going to see with the battle that you people have, unfortunately, and I don't have to mess with that.

Mr. SOUDER. Mr. Wright, could you describe what would happen if Byrne Grants would go away or get dramatically reduced?

Mr. WRIGHT. Byrne Grants are essential to Oklahoma. More than half of the narcotics agents in our State are funded by Byrne funds. They operate 27 independent drug task forces, particularly in rural areas. That has been the single group that has fought this methamphetamine epidemic for the last decade. Those guys do more meth labs in Oklahoma than anyone else, and we are going to be in real trouble if we lose Byrne funding. We lobby for that hard every year.

It also funds a wire intercept project that we have at my agency. We don't just work meth labs, we work Mexican drug cartel cell groups that are operative in Oklahoma, and we do wire tap after wire tap after wire tap on those organizations, and all of those cases lead back to Mexico. That is also Byrne funded. We very much appreciate Byrne funding.

Mr. SOUDER. One of the things that is happening that we have to watch is that the High Intensity Drug Trafficking Areas, the HIDTAs, had a very specific goal. That goal was to work in high-intensity drug trafficking areas to keep the drugs from getting to other areas.

And as Congressmen figured out and Senators figured out that they could get HIDTAs in their home area, the HIDTAs became in some areas like the drug task forces. And as the HIDTAs proliferate, the support for Byrne Grants has declined because HIDTAs became the new trend.

And even though some of their functions are the same and some of them aren't, what is going to happen is if we reduce the Byrne Grants, we are going to see a demand for HIDTAs everywhere. HIDTAs, in effect, will merely become a reconfiguration of the drug task forces, which is starting to happen in some areas already in the country.

And the whole point of border control high intensity distribution networks will be undermined and will have undermined the existing drug task force structure, trying to reinvent another one because we have a new hot name. And it is has been interesting because we haven't really looked at that interrelationship between where the Byrne Grant money is going and where the HIDTA money is going.

Oklahoma is kind of interesting because don't you have a new HIDTA?

Mr. WRIGHT. Yes, sir. We are an extension of the North Texas HIDTA out of Dallas.

Mr. SOUDER. Which is a relatively low-funded HIDTA, so you don't have as much pressure.

Mr. WRIGHT. A very low-funded HIDTA.

Mr. SOUDER. But it is that type of trend, that as that expands, there will be more attention on that money and trying to get that money, and we just move it from one to another and don't get a net in a reconfiguration. So I wanted to make sure we got onto the record here about the Byrne Grants. And we are similarly looking at RISS versus EPIC, and so on.

Did you have something, Sheriff Bundy?

Mr. BUNDY. Just real quickly about the Byrne Grants. I just met with the director of the Kansas Bureau of Investigation last week, and the trend has become that it is the only way that KBI exists, and 46 percent of that budget is from Federal funding now. And in a State like ours that is so rural, where 75 percent are representative of me, we don't have narcotics offices or detectives, we rely on the State agency, being the KBI, for that type of support for the entire State.

So the elimination of Byrne Grants wouldn't so much impact narcotics investigations or specialized services, but the most basic type of services to the citizens of our State would be impacted that day the Byrne Grants are lessened. It plays a huge role in rural States, and I would hate for you not to know of that.

Mr. SOUDER. Well, I thank you all for your testimony today, for your participation. We and many other Members of Congress and the Speaker's drug task force are trying to put together a package here. We are trying to work with everybody involved as to how we do this at the national level. We all know that Internet and international sales complicate all these questions, so we don't just move it to another place.

We want to work with the industry, we want to work with law enforcement to make sure that we can try to keep the meth problem from expanding. While we are focused on this for this particular task, we are working with the industry as well on the other over-the-counter legal drugs that are used and abused by individuals, both for distribution and leading to the death and destruction of many families and individuals around the country.

So, once again, thank you again. If there any additional materials you want to submit, please do so. We will probably give you some additional followup questions both for the record, but as we develop the package together, I am sure that the Narcotics Officers Association, which is a key part of the support for this committee and represents the people on the front lines, as well as trying to

balance that with fairness for the people who need legal drugs to relieve their pain and suffering in many different ways.

Thank you all for participating. With that, the subcommittee stands adjourned.

[Whereupon, at 1:06 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

**Consumer Healthcare Products Association**

December 14, 2004

Mark E. Souder
Chairman
Subcommittee on Criminal Justice,
Drug Policy & Human Resources
Congress of the United States
House of Representatives
Committee on Government Reform
B-373 Rayburn House office Building
Washington, DC 20515

Dear Chairman Souder,

Thank you very much for the opportunity to address follow-up questions, to your November 18, 2004, hearing on the "Fight against Methamphetamine." The questions and answers are enclosed.

It was an honor to appear before your subcommittee and I look forward to working with you and your staff on this important issue in 2005.

Sincerely,

Linda A. Suydam, D.P.A.
President

Enclosure

900 19th Street, NW
Washington, DC 20006
Tel: 202-429-9260
Fax: 202-223-6835
www.chpa-info.org

1. **Many people have advocated for the creation of "Meth Watch" programs, similar to that created in Kansas. What are the most important elements of such a program, in your opinion? How should these programs be financed? Should the cost be shared between law enforcement agencies, manufacturers, and retailers?**

   A central goal of the Meth Watch program is to promote cooperation between retailers and law enforcement to prevent the diversion of legitimate products for illegal use. Community awareness and involvement is another key component of the Meth Watch program. Meth Watch is relatively inexpensive to maintain once developed. Partnerships between the public and private sectors have proven very effective in the past, but government involvement could ensure a steady source of funding.

2. **Should Congress provide financial or other incentives for further research into chemicals that would be substitutes for pseudoephedrine, but can't be used for meth production? Do you believe that such chemicals can be produced – and that no one would be able to figure out how to use them for meth production? How much would it cost to develop such a drug and have it approved by the federal Food and Drug Administration?**

   Yes. Some of our member companies have been working on developing "lock technology" already. This technology would essentially prevent the conversion of pseudoephedrine into methamphetamine. To date, this research has not been successful based on DEA standards. Federal funding of NIH, academic institutions, and financial incentives of industry to develop this technology is an important step in stopping methamphetamine production.

   Costs of developing a substitute decongestant for pseudoephedrine would be difficult to assess at this stage, but could be in the hundreds of millions of dollars.

1. **Why would national uniformity of pseudoephedrine product sales be important?**

National uniformity of pseudoephedrine product sales is important because it will help with both implementation and enforcement of the law. Retailers will be able to implement one consistent standard within their stores across the country and will have to implement only one training program. Having a national single national standard will also aid law enforcement by eliminating conflicting laws across jurisdictional boundaries. We have already seen states implement uniform standards in order to address these issues where local ordinances were too cumbersome.

2. **Should there be a limit on the retail sale of over-the-counter drugs that contain pseudoephedrine?**

CHPA supports a two package or six gram limit on medicines containing pseudoephedrine. CHPA cautions that retail limits alone will not solve the meth problem and encourages a comprehensive approach to reducing methamphetamine production and abuse. California, Oregon, and Washington have all seen reductions in meth labs through comprehensive efforts that include retail sales limits, stiff penalties for meth production and distribution, and other prevention and education efforts, like Meth Watch.

3. **The Drug Enforcement Administration (DEA) has stated that there has been a tremendous increase in the importation of pseudoephedrine over the last 10 years. Has there been a correspondingly large increase in the demand for cough/cold products during the same period?**

According to AC Nielsen, sales of cough/cold products have remained relatively flat over the past five years.

CHPA members have submitted data to DEA showing the amount of pseudoephedrine used in legitimate OTC drug products. This amount does not match the importation levels that DEA is reporting.

CHPA encourages better tracking of pseudoephedrine importation and we look forward to working with DEA on a more accurate and timely system of reporting and reconciliation.

4. **Are there states, other than Kansas and Washington, where "Meth Watch" programs have been successful?**

Meth Watch is a relatively new program that was launched in Kansas in 2002 in response to an emergent need. In 2003, Washington established its program, modeled after Kansas and has been very successful. Oregon has seen significant drops in meth lab busts (Oregon meth lab busts dropped from 595 in 2001 to 406 in 2003).

Currently, in 2004, nine states have a meth watch program in place (IA, MT, ND, OR, TN, TX, VA, KS and WA) and others, including Georgia and North Carolina, are poised to launch the program as well.

We look forward to working with these states to establish and monitor the Meth Watch program so that they, too, can share in the successes of Kansas and Washington.

5. **Does your association support registration of retailers and distributors of over-the-counter drugs that contain pseudoephedrine?**

Yes. This will provide law enforcement with an accurate and up-to-date list of where PSE products are being sold. Manufacturer, wholesalers, and distributors are already required to be registered with DEA.

**U.S. Department of Justice**

Office of Legislative Affairs

Office of the Assistant Attorney General

*Washington, D.C. 20530*

February 28, 2005

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

Dear Mr. Chairman:

Enclosed please find responses to questions posed to Mr. Domingo S. Herraiz, Director, Bureau of Justice Assistance, Office of Justice Programs, following Mr. Herraiz's appearance before the Subcommittee on November 18, 2004. The subject of the hearing was "Law Enforcement and the Fight Against Methamphetamine."

We hope that this information is helpful to you. Please do not hesitate to call upon us if we may be of additional assistance in connection with this or any other matter.

Sincerely,

William E. Moschella
Assistant Attorney General

Enclosure

cc: The Honorable Elijah Cummings
Ranking Minority Member

**COMMITTEE ON GOVERNMENT REFORM**
**SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES**

**"LAW ENFORCEMENT AND THE FIGHT AGAINST METHAMPHETAMINE"**

**NOVEMBER 18, 2004**

**FOLLOW-UP QUESTIONS FOR THE WRITTEN RECORD FOR DOMINGO S. HERRAIZ, DIRECTOR, BUREAU OF JUSTICE ASSISTANCE, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE**

**1. How well coordinated are the various grant programs which deal with meth enforcement? Does ONDCP and/or the Justice Department actively coordinate the Byrne, COPS, OCDETF, and HIDTA dollars going to meth enforcement? Does Congress need to authorize a mechanism to coordinate those dollars?**

The Bureau of Justice Assistance (BJA), the Office of Justice Programs (OJP), the Office of Community Oriented Policing Services (COPS), and ONDCP work very closely together on many issues and will be working even closer together as ONDCP begins its Synthetic Drugs Interagency Working Group. Also, as the written statement indicates, BJA, in close coordination with COPS and ONDCP, as well as other federal agencies, intends to establish a methamphetamine resource center that will coordinate information on available resources, such as grant funding and training, and make this information readily available to state and local law enforcement.

**2. Why are COPS "Meth Hot Spots" grants and Byrne grants administered by two separate agencies within the Justice Department? Should they be combined?**

Funding administration is a function of how Congress appropriates the funds, with Byrne grant authority and funding within OJP, and recent methamphetamine grants included within the COPS' appropriation.

**3. It is our understanding that the Byrne Grants, particularly the block grants, are given to the states with few reporting requirements attached. This makes it virtually impossible for you to determine with any accuracy exactly how the dollars are being spent by the states -- including how much is spent on meth enforcement. What kind of reporting requirements would you need to do that kind of accounting? How burdensome would that be for the states?**

As you know, the Congress has now authorized the Byrne Justice Assistance Grants Program (JAG), which will combine the resources and authorities of both the Byrne Formula Grants Program and the Local Law Enforcement Block Grants Program (LLEBG). The Fiscal Year 2005 Omnibus Appropriations bill includes $634 million for JAG.

Building on lessons learned from years of administering the Byrne Formula Program and LLEBG, BJA will seek to capture accurate and more detailed reporting information from states, in order to measure outcomes and impact derived from the JAG funding. This reporting should also allow many successful state and local programs to be identified and highlighted.

BJA has discussed this need with State Administering Agencies (SAAs) and has received their support in moving forward. SAAs and BJA are in agreement that any additional burden (which would be limited and balanced) is necessary and worth providing in order to demonstrate the value of the program and the funds. We will keep Congress informed as we receive more detailed reporting information.

**4. What kind of "performance measures of effectiveness" do you have in place for the COPS Meth Hot Spots grants? How can you verify whether they're being put to good use?**

The COPS Office carefully scrutinizes each grant request to ensure the law enforcement grantee will use the federal funds to effectively address methamphetamine issues. The COPS Office delivers annual training, with the DEA and EPA, to all COPS Methamphetamine Initiative grantees to provide technical assistance to effectively address methamphetamine issues. Finally, an Institute for Law and Justice evaluation of COPS Methamphetamine Initiative grantees found that law enforcement agencies that used COPS grants to create community policing solutions to methamphetamine issues were effective in combating that drug.

**5. The Administration has proposed consolidating the Byrne Grants with other law enforcement grant programs into a single "Justice Assistance Grants" program. It has also proposed cutting the total budget for that combined grant program by as much as 50%. State and local law enforcement authorities have warned us that such cuts would have a severe impact on drug enforcement at the state and local level. Do you believe that to be the case? Why or why not?**

As noted, Congress established the Byrne Justice Assistance Grants (JAG) Program in FY 2005 and appropriated $634 million for this purpose. JAG combines and consolidates the best features of the Byrne and Local Law Enforcement Block Grants programs. The JAG program collapses the seven specific purpose areas of the LLEBG Program and the 29 specific, repetitive purpose areas of the Byrne Program into five broad purpose areas that reflect the expanse of the criminal justice system. The consolidation of these grant programs into JAG will eliminate duplication and will allow for more efficient administration and service at the federal level. A streamlined program, with a single solicitation and application process, will also assist the state and local grantees in planning, and reduce the current time-consuming application processes. It is our belief that easing the burden on state and local grantees will enhance, not hinder, drug enforcement, including efforts to combat methamphetamine abuse.

BJA will continue to support law enforcement efforts not only through grants and funding, but also through critical training and technical assistance. For example, BJA has more than tripled the number of Methamphetamine Task Force Commanders' Workshops it will provide in FY 2005, and expects to provide additional training in FY 2006.

**6. How effective have the various drug court programs funded by the federal government been in dealing with meth abuse and addiction? How would you like to see these programs improved to better deal with meth-related crime?**

For more than a decade, many local drug courts have been quite effective in dealing with methamphetamine addicts. BJA-funded drug courts from California to Kentucky and from Oklahoma to Hawaii have been using the drug court model — pairing the coercive power of the justice system with the evidence-based treatment strategies — to address addiction in some of the most methamphetamine-impacted areas of our nation.

Drug courts tackling the methamphetamine epidemic have demonstrated that intensive community supervision, increased and random home visits, longer treatment, treatment for dual diagnoses, and pharmacological interventions are among the most effective strategies for the methamphetamine-addicted population. Using these tested methods, drug courts are building safer communities, reducing recidivism, reuniting families, and promoting abstinence from this devastating drug.

Three drug courts that work primarily with methamphetamine users have reported positive results. For example, a recent study of the BJA - funded drug court in Salt Lake County, Utah showed that only 15.4 percent of those who completed the Salt Lake County program were later arrested on new drug charges, compared to 64 percent of similar offenders who did not go through the program.

In addition, two BJA-funded drug court programs in Orange County and Butte County, California, also work primarily with methamphetamine users. The Butte County adult drug court has been in operation since 1995, and produced approximately 500 graduates, with a recidivism rate of less than 15 percent.

Helen Harberts, Deputy District Attorney for Butte County and lifetime member of the California Narcotics Officers' Association, has said: "We are 30 years deep in the methamphetamine epidemic in Butte County, California, and drug courts are the only thing that has worked with this population."

The Orange County Drug Court also began operations in 1995 and has successfully graduated over 1,000 offenders. This program shows a 72 percent retention rate, with 80 percent of the graduates having no re-arrest for a drug related crime, and 74 percent having no re-arrests at all.

The encouraging news is not limited to low recidivism. In 2003, 62 percent of offenders admitted into the Orange County Drug Court program were unemployed. By the time they graduated, 100 percent of these offenders were gainfully employed or actively involved in a job training program.

**7. How many state or local agencies have received training related to methamphetamine enforcement or environmental clean-up from Justice Department programs or subdivisions?**

BJA offers Methamphetamine Task Force Commanders' Training Workshops through its Center for Task Force Training (CenTF). In 2004, CenTF provided training to nearly 1,300 state and local agencies, bringing the total number of agencies that have received training since 1998 to 4,183. In addition, nearly 1,000 law enforcement personnel have received training and technical assistance from the COPS Office on methamphetamine enforcement and clean-up. Further, the Drug Enforcement Administration's Office of Training, Clandestine Laboratory Training Unit, trained 393 agencies (549 students) in Basic Certification and Site-Safety classes. These classes comply with OSHA's standards, as set forth in section 1910 of title 29 of the Code of Federal Regulations and cover enforcement and waste disposal issues.

U.S. Department of Homeland Security
United States Coast Guard

Commandant
United States Coast Guard

2100 Second Street, S.W.
Washington, DC 20593-0001
Staff Symbol: G-ICA
Phone: (202) 366-4280
FAX: (202) 366-7124

5730

NOV 12 2004

The Honorable Mark E. Souder
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you very much for the opportunity to testify at the investigative hearing entitled, "Law Enforcement and the Fight Against Methamphetamine," being conducted by the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy, and Human Resources. However, Coast Guard forces engaged in counter-drug operations have not seen methamphetamine, Yaba, or precursor chemicals in our interdiction efforts nor do we have any intelligence that points to it coming into the country via maritime means. The few cases of methamphetamine law enforcement that the Coast Guard has been involved with were in support of local law enforcement agencies investigating floating laboratories.

Based on our analysis and experience with methamphetamine in the maritime environment, Coast Guard participation in this hearing would not appear to add value to the other witnesses' testimony. I would be pleased to brief you or your staff on more specifics of the Coast Guard's role. If the scope of the hearing is broader, we would be glad to provide an appropriate witness.

Sincerely,

J. W. UNDERWOOD
Rear Admiral, U.S. Coast Guard
Director of Operations Policy

**Carnegie Mellon**

**H. John Heinz III School of Public Policy and Management**
Carnegie Mellon University
Pittsburgh, Pennsylvania 15213-3890
(412) 268-9590
Fax: (412) 268-5338
caulkins@andrew.cmu.edu

**Jonathan P. Caulkins**
Professor of Operations Research and Public Policy

November 22, 2004

Drug Policy Subcommittee
US House of Representatives
B-373 Rayburn Building
Washington, DC 20515

Dear Sir or Madam:

The other day on CSPAN I caught the tail end of Representative Mark Souder closing a hearing on methamphetamine. I thought you might be interested in the enclosed paper I published last year on the spread of methamphetamine.

I'm also enclosing my resume and a list of publications. If any others might be of interest, you can obtain them from me or my assistant, Gretchen Hunger (412 268 6076 or ghunter@andrew.cmu.edu).

Sincerely,

Jonathan P. Caulkins

# Methamphetamine Epidemics: An Empirical Overview

**Jonathan P. Caulkins, Professor of Operations Research and Public Policy, Carnegie Mellon University, Heinz School of Public Policy**

## Introduction

By all accounts, methamphetamine (meth) use is a significant problem in the United States that is growing in some regions. It raises unique challenges for law enforcement and difficult strategic questions. This article seeks to provide some context for and insight into these questions by looking at historical and spatial patterns in meth-related data indicators.

A guiding principle motivating this exercise is the idea that drug control policy ought to adapt over the course of a drug epidemic and that law enforcement is particularly valuable early in an epidemic cycle. For many illicit drugs, it is clear what stage of the epidemic cycle pertains. Cocaine and marijuana passed through periods of epidemic growth but are now endemic. MDMA is still in epidemic growth (Caulkins, 2000). Heroin is most likely endemic, with reports of small epidemics in places where use has heretofore been rare, such as in rural areas (Hogue, 2001) and suburbs surrounding small- and medium-sized cities (e.g., Prine, 2003).

The issue is more complex for meth for at least two important reasons. First, there is extreme spatial variation in meth use patterns. It is entirely possible that use has stabilized at endemic levels in some western cities at the same time it is growing contagiously in the Midwest and has not even kicked into rapid spread in some East Coast cities. Unfortunately, there is at present very limited knowledge concerning how the existence of a matured epidemic in one location affects a possible new epidemic in a different location (Behrens, Caulkins, & Tragler, 2002).

Second, while information pertaining to illicit drug use and markets is generally poor (Manski et al., 2001), that pertaining to meth is even harder to work with than data for, say, cocaine or marijuana. An indicator of the severity of the problem comes from comparing two pairs of recent official estimates of meth prices, supply, and consumption. The Office of National Drug Control Policy (ONDCP) issued two documents in 2001 (ONDCP, 2001a, 2001b) that included dramatically different annual series for meth prices from 1988 – 2000. The correlation between the two series was only 0.3.[1] Likewise ONDCP (2001b, p. 23) estimates that total U.S. meth consumption quintupled from 10.0 to 54.2 metric tons between 1991 and 1995, before falling back to 18 – 20 metric tons in 1999 and 2000. In contrast, the Drug Availability Steering Committee (2002, p. 74), chaired by the Drug Enforcement Administration, estimates that there were 106.5 – 144.1 metric tons of meth available for consumption in the United States in 2001. To be fair, both documents are quite forthright about the enormous uncertainty surrounding their estimates.

The objective of this article is to overcome these challenges by assembling, synthesizing, and interpreting spatially disaggregated descriptive statistics concerning trends in a meth-related data series. Hopefully this will help policymakers to better understand the current nature and perhaps even the future trends of the



meth epidemics in the United States. (Epidemics are intentionally referred to in the plural because meth trends in the United States are better understood as an agglomeration of many city- and region-specific phenomena, not as a single national epidemic.) Before proceeding to the data, we first briefly review key findings and insights concerning how and why law enforcement's effectiveness may vary over the course of an epidemic cycle.

## Overview of Models of Drug Enforcement, Drug Epidemics, and Issues of Timing

Historically, drug use has changed far more dramatically and rapidly than one would expect from exogenous factors alone (Caulkins, 2001). Such extreme variation in drug use has long been described in "epidemic" terms (Bell & Champion, 1977; Hunt & Chambers, 1976), and meth is no exception in this regard (Brill & Hirose, 1969; Tamura, 1989). These are not literally epidemics since there is no pathogen as with HIV or the flu. Nevertheless, drug use is "contagious" in the sense that use by one person can influence initiation by another, as in models of the diffusion of ideas, fads, and consumer product adoption (Bass, 1969).

Since the dynamics of drug initiation, escalation, and use vary so dramatically over an epidemic cycle, it would not be surprising if the effectiveness of various drug control strategies likewise varied over the course of the epidemic (Caulkins, 2001, forthcoming). In recent years, this possibility has been investigated intensively using models that embed market dynamics and the impact of various interventions within a contagious epidemic framework. A common finding is that supply-control interventions in general are relatively most effective in the early, exponential growth stages of a drug epidemic (Tragler, Caulkins, & Feichtinger, 2001), and later, when use is more endemic, treatment and other styles of enforcement may be more productive (Caulkins, 2002).

There are several intuitive ways of understanding why these models produce this result. One is simply that early in an epidemic, demand is spreading very rapidly and has in some sense outstripped supply. Later, demand plateaus and the supply of drug sellers catches up because high-profits attract more entrants, prior convictions create "barriers to exit," or the technology of production diffuses. So late in an epidemic, removing sellers can bring only modest benefits because incarcerated sellers are easily replaced (Kleiman, 1997). Early in the epidemic, they are the "constrained" or "limiting factor," so their removal can reduce availability and slow the contagious spread.

Even early in an epidemic incarcerated sellers can eventually be replaced, so it may not be obvious why the models find such a striking difference in effectiveness. The answer lies in the workings of a nonlinear dynamical system that has a positive feedback (e.g., the contagious spread of initiation) tempered by some perhaps lagged negative feedback. In such circumstances, interrupting supply during the explosive growth stage not only delays the peak in use, but also reduces the magnitude of that peak (Behrens, Caulkins, Tragler, & Feichtinger, 2000). Depending on the details of the model and the timing of the intervention, the temporary disruption can in some circumstances lead to a quite dramatic moderating of the subsequent course of the epidemic.

One class of models, which yields amplified effects of enforcement when properly timed, is "tipping point" models (Schelling, 1978). Tipping models are characterized by (at least) two stable equilibria. Either low or high levels of use can persist indefinitely absent some intervention or exogenous shock. These models view explosions in drug use as instances of "tipping" from the low to the high level equilibrium. One implication is that policymakers should do whatever they can to prevent that tipping (Kleiman, 1993; Tragler et al., 2001). In other words, timely and aggressive investments in enforcement that cut short contagious spread may keep the drug from becoming a truly mass market phenomenon.

A second class of such models includes lagged negative feedback from drug use to initiation. Musto (1973) hypothesized from long-run historical considerations that when some users progress to dependence, they serve as a sort of negative advertisement warning potential initiates of the drug's dangers. Egan's (1999) journalistic description of the ebbing of New York City's crack epidemic is similar in spirit. This qualitative model was elaborated by Kleiman (1992) and formalized by Behrens, Caulkins, Tragler, Haunschmeid, & Feichtinger (1999); Behrens et al. (2000); and Behrens, Caulkins, Tragler, & Feichtinger (2001).[3] A key finding is that interventions that slow the spread of an epidemic until the endogenous negative feedbacks take effect can prevent the worst effects of the positive feedback loop surrounding initiation.

Understanding of how enforcement and other drug control interventions interact with dynamic epidemiological models of the spread of drug use is still evolving. Nevertheless, there are strong plausible arguments suggesting that enforcement is uniquely effective in the early stages of an epidemic, so it is of interest with respect to meth to inquire as to the stage and nature of the growth trajectory, a topic to which we turn next.

## Long-Term National Trends

Traditionally drug policy has focused on the "big three" illicit drugs: (1) heroin, (2) cocaine, and (3) marijuana. This is reflected, for example, in which drugs are singled out for specific mention in news releases and tabulations of data.[3] In many respects, however, meth rivals heroin and marijuana in importance. (Cocaine remains the most problematic drug in the United States in almost every respect except sheer number of users, for which marijuana is first.) Specifically, in terms of both dollar value of black market revenues and enforcement efforts, meth is roughly comparable to heroin or marijuana. Only in drug-related morbidity and mortality as recorded by the Drug Abuse Warning Network (DAWN) does meth trail significantly.[4] (See Table 1.)

Furthermore, as is discussed below, there is great regional variation in meth use, so at the local and regional level, meth can be even more prominent. For example, according to 2001 ADAM data (cited in Maguire & Pastore, 2002, p. 383), the proportion of adult male arrestees testing positive for meth in Honolulu (38%) is greater than the proportion testing positive for heroin in any city, and for cocaine in any city except New York (46%).



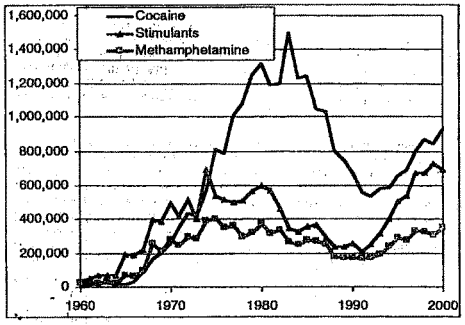
**Table 1**
**Comparison of Magnitude of Problems Associated with Cocaine, Heroin, Marijuana, and Meth**

| Quantity | Source | Year | Cocaine | Heroin | Marijuana | Meth |
|---|---|---|---|---|---|---|
| Black Market ($B) | ONDCP (2001b) | 2000 | $35.3 | $10.0 | $10.5 | $5.4 |
| Chronic Users (millions) | "" | 2000 | 2.7 | 0.9 | — | 0.6 |
| DEA Arrests | Maguire and Pastore (2002) | 2000 | 15,452 | 3,557 | 7,783 | 8,382 |
| % of Federal Drug Prisoners | Sevigny & Caulkins (in submission) | 1997 | 63% | 9% | 15% | 10% |
| % of State Drug Prisoners | "" | 1997 | 69% | 11% | 8% | 9% |
| Average ADAM Arrestee Urinalysis Rate | Maguire and Pastore (2002) | 2001 | 27% | 7% | 42% | 10% |
| DAWN ED Mentions | SAMHSA (2003) | 2000 | 174,881 | 94,804 | 96,426 | 13,505 |
| DAWN ME Mentions | SAMHSA (2000) | 1998 | 4,587 | 4,330 | 598 | 501 |

Some historical context helps to provide a sense of how meth came to be such a significant problem. The longest-running time series one can assemble for meth pertains to the calendar year of initiation as reported retrospectively in the National Household Survey on Drug Abuse (NHSDA).[5] Obviously, there are limitations to such data. Memories are imperfect. Individuals may under-report illegal behavior on government surveys. Some subpopulations are overlooked or under-sampled. Some who initiated many years ago may have died in the interim. Nevertheless, this self-report data may be indicative of broad trends.

Figure 1 compares estimated annual initiation rates for meth, cocaine, and non-prescription use of prescription stimulants based on combined data from the 1999, 2000, and 2001 household surveys.[6] Through 1970, annual initiation rates were higher for meth than for cocaine. Meth initiation continued to grow to a peak of 400,000 in 1975, but cocaine initiation grew far more. All three series fell to lows in the early 1990s but have since rebounded, almost doubling for meth, increasing by about 60% for cocaine, and more than tripling for stimulants.

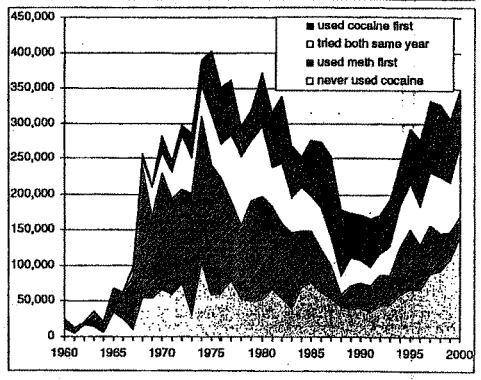
**Figure 1**
**Number of First-Time Users of Meth, Cocaine, and Non-Prescription Use of Prescription Stimulants, 1960-2000**




It is not clear how the cocaine epidemic affected initiation into meth use. To some extent, the two drugs may be substitutes, so the popularity of cocaine may have preempted some meth initiation. On the other hand, individuals who become dependent on cocaine often become polydrug users, at least trying quite a wide range of substances even if cocaine remains their primary substance of abuse. Given the lag between cocaine initiation and dependent use (often several years or more), these considerations suggest that the cocaine epidemic may have dampened meth initiation during the 1970s, when trying cocaine was increasingly popular, but also added some initiates during the 1980s, when heavy users were coming to dominate cocaine consumption (Everingham & Rydell, 1994). Figure 2 offers some circumstantial support for this conjecture by breaking down the meth initiation curve, from bottom to top, into individuals who never used cocaine, those who only tried cocaine after initiating meth, those who started using meth and cocaine in the same year, and those who only tried meth after having initiated cocaine.



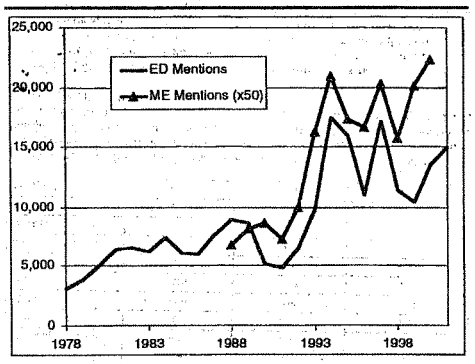
**Figure 2**
**Numbers of People Initiating Meth Use from 1960-2000, Broken Down by Their Level of Prior Cocaine Experience**




If one imagined that those who try meth only after using cocaine merely reflect the polydrug use of existing, committed drug users and, hence, are less indicative of the contagious spread of meth among new users, then the decline and rebound of meth initiation before and after 1990 is even more pronounced. That is, Figure 1 suggests that meth use spread rapidly in the early 1960s and has averaged about 280,000 initiates per year since 1970, roughly doubling from a trough of 170,000 around 1990 to about 350,000 in 2000. Excluding those who initiated cocaine a year or more before trying meth obviously reduces the average number of meth initiates (to 215,000), but it makes the recent run-up more dramatic, roughly a tripling from about 90,000 in 1990 to 270,000 in 2000.[7]

The increase in initiation during the 1990s has been paralleled in general by increases in emergency department (ED) and medical examiner (ME) mentions recorded by DAWN.[8] (See Figure 3.) There have been abrupt and not insubstantial variations in these DAWN series. Cunningham and Liu (forthcoming) suggest that similar oscillations in hospital admissions for meth may be linked to regulations designed to control precursors, although Reuter and Caulkins (forthcoming) note that other related trends showed at most weak concordance.[9]

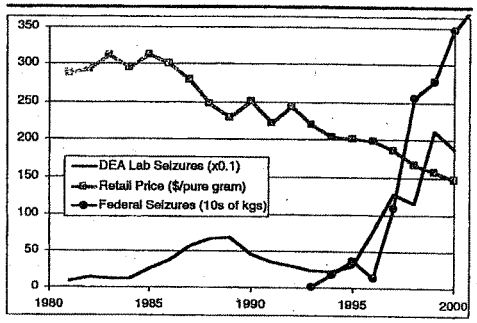
**Figure 3**
**DAWN-Measured Trends in Meth-Related Emergency Department and Medical Examiner Mentions**




One would like to likewise plot long-term trends in meth enforcement, but this is complicated by the fact that standard-tabulations of criminal justice statistics infrequently separate out meth-related activity explicitly (e.g., Uniform Crime Report (UCR) data breaks down arrests only by marijuana, cocaine/heroin, and other drugs). Figure 4, however, shows numbers of meth labs seized by the DEA (Maguire & Pastore, 2002), quantity of meth seized by all federal agencies (ONDCP, 2003), and average retail meth prices, as reported by ONDCP (2001a). The patterns for these two indicators parallel those for cocaine and heroin, namely, prices drifting lower despite increased enforcement pressure (Bushway, Caulkins, & Reuter, in submission; Caulkins & Reuter, 1998).



**Figure 4**
**ONDCP (2001a) Reported Meth Prices Have Drifted Lower Despite Increased Enforcement Activity by the Drug Enforcement Administration**




## Regional Variation in Meth Markets

As we have just seen, in broad outlines, aggregate national data concerning meth can be characterized as follows: explosive growth in the 1960s, some oscillation with a general downward trend through 1990, and a substantial rebound (at least a doubling) since 1990.

Some drugs (e.g., cocaine and marijuana) have essentially national distribution and markets, so such aggregate patterns are mirrored to a greater or lesser extent in most cities and regions. Others manifest striking geographic variation. For example, in the late 1980s and again in the mid-1990s, rates of arrestees testing positive for PCP in Washington, DC, were many times higher than they were a few miles away in Baltimore.[9]

Meth is more like PCP in this regard. By at least some measures, it displays the greatest spatial variation in use, at least among the most important drugs of abuse. Table 2 illustrates this in terms of DAWN ED mentions in 2001 (SAMHSA, 2002a). For each major substance of abuse and each city, numbers of drug-specific mentions were normalized by the total number of ED mentions for all causes in that city. This helps adjust for the different sizes of different cities. Looking only at raw numbers of meth mentions might suggest that Los Angeles, with 1,517 mentions, has a more acute problem than either Phoenix (604 mentions) or San Francisco (611 mentions). Los Angeles, however, is simply a bigger city and has more ED mentions in total (2,435,000) than do Phoenix or San Francisco (937,000 and 545,000, respectively). So, the number of meth mentions per 1,000 total ED mentions for Los Angeles and Phoenix in that year were similar (0.62 and 0.64, respectively), and San Francisco

appears to have had the more acute problem (1.12 meth ED mentions per 1,000 total ED mentions).

Having made this normalization, Table 2 then shows the average, standard deviation, and coefficient of variation of the normalized ED mention rates across cities for which DAWN data is reported. (The coefficient of variation is simply the standard deviation divided by the mean. It is a measure of the amount of variation in drug mentions across cities relative to the average rate.) With the exception of Rohypnol, for which the numbers of ED mentions are very small (just 23 in total across all the cities), methamphetamine displays the greatest coefficient of variation (1.31), exceeding even that of PCP (1.20). Not surprisingly, the most widely used substances (alcohol and marijuana) have the lowest coefficients of variation (0.34 and 0.35, respectively). Cocaine is only a bit higher (0.47), reflecting its national distribution.

**Table 2**
**Methamphetamine Has Greater Variation Across Cities in Rates of DAWN Emergency Department Mentions in 2001 Than Does Any Other Major Drug**

| Substance | Average | Standard Deviation | Coefficient of Variation |
|---|---|---|---|
| Cocaine | 3.86 | 1.81 | 0.47 |
| Alcohol in Combination | 3.68 | 1.24 | 0.34 |
| Heroin | 2.26 | 1.53 | 0.68 |
| Marijuana | 1.92 | 0.68 | 0.35 |
| Amphetamines | 0.46 | 0.45 | 0.97 |
| Methamphetamine | 0.28 | 0.37 | 1.31 |
| PCP | 0.12 | 0.15 | 1.20 |
| MDMA | 0.10 | 0.06 | 0.64 |
| GHB | 0.06 | 0.07 | 1.14 |
| LSD | 0.04 | 0.02 | 0.56 |
| Misc. Hallucinogens | 0.03 | 0.03 | 1.10 |
| Inhalants | 0.01 | 0.02 | 1.19 |
| Ketamine | 0.01 | 0.01 | 0.76 |
| Rohypnol | 0.00 | 0.00 | 1.95 |

Results are similar for 2001 ADAM data, as reported by Maguire and Pastore (2002, p. 383), concerning the proportion of male arrestees who test positive across 31 cities. Marijuana shows the smallest coefficient of variation (0.17). Cocaine and heroin are intermediate (0.34 and 0.65, respectively). Methamphetamine is much higher (1.14), with only PCP (1.40) showing greater spatial variation.

Although spatial variation in meth use is substantial, it is not purely random. There are regional effects (e.g., monthly time series on treatment admissions for methamphetamine in California and neighboring Oregon are strongly correlated).[11] DAWN medical examiner data for the six cities with the most mentions between 1988 and 2000 shows something similar. (See Table 3.) There is a clear geographic relationship. Trends in meth medical examiner (ME) mentions for cities that are



physically close (most noticeably Los Angeles and San Diego) are highly correlated. Philadelphia, the only one of the six cities that is east of the Mississippi, stands out as an outlier from the other five.

**Table 3**
**Correlation in Meth ME Mentions from 1988-2000**
**(Dark shading indicates high correlation; light shading, medium correlation)**

| | San Francisco | Los Angeles | San Diego | Dallas | Phoenix | Philadelphia |
|---|---|---|---|---|---|---|
| San Francisco | [illegible] | [illegible] | [illegible] | 0.29 | 0.65 | 0.14 |
| Los Angeles | [illegible] | [illegible] | 0.95 | [illegible] | [illegible] | -0.07 |
| San Diego | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 0.00 |
| Dallas | 0.29 | [illegible] | [illegible] | [illegible] | [illegible] | -0.22 |
| Phoenix | 0.65 | 0.66 | 0.66 | [illegible] | [illegible] | -0.49 |
| Philadelphia | 0.14 | -0.07 | 0.00 | -0.22 | -0.49 | [illegible] |

As is well-known, longitude is a strong predictor of this variation: meth is far more common in the western parts of the United States than in the East.[12] Table 4 illustrates this by ranking cities in terms of meth ED mentions per 1,000 total ED mentions in 2001. Except for Atlanta (normalized meth ED rate of 0.14) exceeding Saint Louis (0.13) and Dallas (0.11), no city east of the Mississippi River had a higher normalized DAWN meth ED rate than did any city west of the Mississippi.

**Table 4**
**Meth DAWN ED and ADAM Urinalysis Rates are Higher West of the Mississippi**

| City | Meth DAWN ED Mentions in 2001 per 1,000 Total ED Mentions | % of Male Arrestees Testing Positive for Meth in 2001 |
|---|---|---|
| San Francisco | 1.12 | NA |
| San Diego | 1.08 | 27 |
| Phoenix | 0.64 | 25 |
| Los Angeles | 0.62 | NA |
| Seattle | 0.56 | 11 |
| Minneapolis | 0.40 | 3 |
| Denver | 0.17 | 4 |
| Atlanta | 0.14 | NA |
| St. Louis | 0.13 | NA |
| Dallas | 0.11 | 2 |
| Miami | 0.04 | NA |
| Philadelphia | 0.03 | 0 |
| Chicago | 0.02 | NA |
| Washington | 0.02 | NA |
| Buffalo | 0.01 | NA |
| Boston | 0.01 | NA |
| Baltimore | 0.01 | NA |
| Newark | 0 | NA |

This east-west spatial variation in ED mentions appears to be mirrored by spatial variation in meth retail price and purity, as reported by the ONDCP (2001a). There are relatively few purchase observations upon which such annual price series can be estimated, so the series are noisy. Hence, Table 5 reports simple averages over 1991-2000 of retail prices and purity (i.e., for purchases of 10 grams or less). Still, it is clear that the purity is higher and purity-adjusted prices lower in the western regions with the greatest rates of use, as measured by DAWN.

**Table 5**
**Average Retail Methamphetamine Price and Purity Indicate Greater Availability in the Western United States than in the East**

| Region | Price per Pure Gram | Purity |
|---|---|---|
| Pacific | $256 | 45 |
| Mountain | $495 | 35 |
| West Central | $655 | 26 |
| Northeast | $672 | 19 |
| East Central | $706 | 23 |
| Southeast | $742 | 22 |

## Inverse Correlation in Regional Variation Between Meth and Other Substances

There is another perspective on spatial variation in meth use that is less widely appreciated. To some extent, meth appears most common in those cities where the "big three" illicit drugs are less common. That is, there is an inverse correlation between meth ED mention rates per 1,000 total ED mentions and the corresponding rates of these three other substances. Conversely, meth rates are positively correlated with three other amphetamine-related compounds (i.e., amphetamines, ketamine, and MDMA) and several other miscellaneous substances (e.g., LSD and GHB), many of which are "club drugs" or are associated with rave culture.

Table 6 shows that to some extent one can view this as two "blocks" of substances: (1) the "big three" plus alcohol-in-combination and (2) methamphetamines and most other illicits.[13] In particular, the table shows pairwise correlations across substances, with dark shading indicating positive correlations of one-half or more and light shading indicating positive correlations of one-third to one-half. This blocking is far from perfect. There are DAWN cities with high rates of ED mentions for cocaine but not heroin (notably Atlanta and Miami) and vice versa (Newark and San Francisco). In contrast, among Table 4's list of cities with high rates of DAWN meth mentions, with the exception of San Francisco's high-rates of heroin mentions, none has unustially high rates of mentions for any of the traditional "big three" until one drops all the way down to Atlanta (and its high rates of cocaine use).



**Table 6**
**Correlations Across Cities in DAWN ED Mentions per 1,000 Total ED Mentions for Pairs of Substances Blocked into Two Groups: (1) The "Big Three" Illicits Plus Alcohol in Combination and (2) Meth and Almost All Other Illicit Drugs**

| | Alc. | Coke | MJ | Heroin | Amphet | Meth | MDMA | Ket. | LSD | Misc H | GHB |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol in Combo | | | | 0.21 | -0.21 | -0.10 | 0.23 | -0.34 | 0.25 | -0.07 | -0.17 |
| Cocaine | | | | | -0.32 | -0.30 | 0.31 | -0.29 | -.20 | -0.17 | -0.08 |
| Marijuana | | | | -0.05 | -0.25 | -0.22 | 0.12 | -0.39 | 0.17 | -0.15 | -0.30 |
| Heroin | 0.21 | | -0.05 | | 0.05 | -0.08 | 0.21 | 0.28 | -0.13 | -0.01 | 0.17 |
| Amphetamines | -0.21 | -0.32 | -0.25 | 0.05 | | | | | | | |
| Methamphetamine | -0.10 | -0.30 | -0.22 | -0.08 | | | | | | | |
| MDMA | 0.23 | 0.31 | 0.12 | 0.21 | | | | 0.23 | | | |
| Ketamine | -0.34 | -0.29 | -0.39 | 0.28 | | | 0.23 | | 0.09 | 0.25 | |
| LSD | 0.25 | 0.20 | 0.17 | -0.13 | | | | 0.09 | | | 0.37 |
| Misc. Hallucinogens | -0.07 | -0.17 | -0.15 | -0.01 | | | | 0.25 | | | 0.48 |
| GHB | -0.17 | -0.08 | -0.30 | 0.17 | | | | | 0.37 | 0.48 | |

Parallel analysis with ADAM data concerning arrestees' rates of testing positive in 2001 shows that the strongest positive correlation is between cocaine and heroin (0.49) and the strongest negative correlation is between cocaine and methamphetamine (-0.75). Indeed, rates of testing positive for cocaine and methamphetamine are so strongly negatively correlated that the sum of their two rates is remarkably stable across the 31 cities, with a coefficient of variation almost as low as that for marijuana.[14] That is, cities with high cocaine rates had low meth rates and vice versa, so the total rate of "stimulants" (cocaine + meth rates) varied only modestly across cities. (See Table 7.)

**Table 7**
**For Proportions of Arrestees Testing Positive as Measured by ADAM in 2001, Results for Methamphetamine Vary Dramatically Across the 31 Cities, but the Sum of Meth + Cocaine Rates Shows Much Less Variation**

| | Min | Max | Mean | Std Dev | Coeff of Var |
|---|---|---|---|---|---|
| Cocaine | 9 | 46 | 26.8 | 9.1 | 0.34 |
| Marijuana | 27 | 58 | 42.1 | 7.1 | 0.17 |
| Opiates | 1 | 18 | 6.5 | 4.3 | 0.65 |
| Methamphetamine | 0 | 38 | 10.0 | 11.5 | 1.14 |
| PCP | 0 | 9 | 1.5 | 2.2 | 1.40 |
| Cocaine + Meth | 20 | 53 | 36.8 | 7.6 | 0.21 |

There may also be some rural-urban variation [e.g., 2001 NHSDA (based on author's analysis of data available at www.icpsr.umich.edu/SAMHDA/) respondents living outside a metropolitan statistical area (MSA) were 25% more likely than those living in an MSA to report past-year use of meth]. They were also 13% more likely to report past-year use of a prescription stimulant without a prescription (but 30% less likely to report past-year cocaine use).

What is perhaps even more striking than the spatial variation is the ethnic variation. In 1998, for both white and Hispanic decedents in the DAWN Medical Examiner system, meth/speed was the sixth most commonly mentioned substance. For blacks, it did not even make the list of the top 15 substances, falling somewhere below number 15 Doxepin's 1.62% mention rate (SAMHSA, 2000, p. 42). Likewise, blacks account for just 3.4% of mentions of stimulants between 1995-2000 in the Treatment Episodes Dataset, and non-white/black high-school senior's lifetime prevalence of amphetamine use has persistently been just 30-40% that of the aggregate figures since the beginning of the survey. In the 2001 NHSDA, Non-Hispanic Black/African-American respondents were only one-fifth as likely to report past-year meth use as were respondents generally. Non-Hispanic Asians were also substantially under-represented, with past-year meth use rates just half those for the nation as a whole.

## City-Specific Variation In Methamphetamine Indicators Over Time

The discussion above has established two elementary points. First, aggregate national statistics indicate substantial increases in meth use since 1990. Second, there is so much spatial variation in meth use patterns that national aggregate statistics are of questionable value, no matter whether one looks at that spatial variation in terms of longitude (i.e., meth use is common in the West but not the East) or availability and use of other substances. What one needs, both to understand past variation and project the future, is city- or region-specific time series. At that level of geographic specificity, there are four principal sources of data: (1) DAWN ED mentions, (2) DAWN ME mentions, (3) treatment admissions, and (4) ADAM data on arrestees.

Trends in DAWN ED mentions between 1991-2001 are quite interesting. (See Figure 5.) The total counts are dominated by a handful of cities. In particular, three cities in California (Los Angeles, San Francisco, and San Diego) account for 63% of all mentions for the 21 cities over this time period. The trend in these cities was an increase through about 1994; then there was a decline through about 1999, with a subsequent rebound (partial rebound for San Diego and San Francisco, complete for Los Angeles). The pattern is very similar in Phoenix (13% of all mentions), Dallas (3.0% of mentions), and Denver (2.7%), with peak numbers of mentions in 1994, 1995, and 1995, respectively.

The "rest of the West" area in the figure is dominated by Seattle (7% of all mentions), which shows a different pattern, with mentions in each year from 1999-2001 exceeding the local peak in 1994. The pattern is similar for the other three cities in the "west" layer, although they are geographically "middle" cities (Minneapolis with 3% of all mentions, St. Louis with 2%, and New Orleans with 0.4%). It is by no means clear that the worst of the meth epidemic has passed in these cities, as measured by DAWN ED mentions.

Meth ED mentions east of the Mississippi River are dominated by Atlanta (36% of mentions east of the Mississippi) where DAWN mentions peaked in 1997 at 214 but rebounded in 2001 to 172, and Philadelphia (28% of mentions east of the Mississippi), where the epidemic appears to have been in decline since 1992. In the remaining nine East Coast cities (accounting for just 2.1% of all mentions), counts reached 120 per year in 1994 and have not varied much since.



Figure 5
**Meth DAWN ED Mentions by City, 1991-2001**

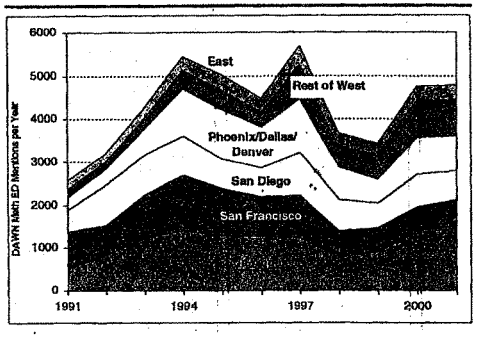
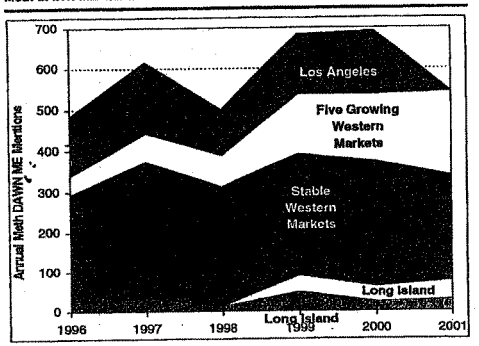



Figure 6 plots DAWN ME data available from 1996-2001 for 36 cities (SAMHSA, 2002b, 2003). One complication is that three cities did not report in 2001. For one, this is inconsequential. Norfolk had no meth ME mentions from 1996-2000. New York City also did not report. For most drug-related time series that is a major omission, but meth ME mentions in New York from 1996-2000 were 0, 5, 0, 2, and 3, respectively, so plotting New York's 2001 missing data point as if it were a 0 is not a major distortion. The third missing city, however, is Los Angeles. It had the most meth ME mentions in each of the years 1996-2000. So Figure 6 devotes a separate area block just to Los Angeles so the artificial decline from 155 mentions in 2000 to "0" in 2001 is visible and can mentally be adjusted for.

The regional variation in Figure 6 mostly parallels that in Figure 5, but the aggregate trend is stable, not declining. As with the ED data, the majority of mentions come from western cities whose numbers of mentions per year are fairly stable. Those cities were Los Angeles and the collection of cities labeled "Stable Western Markets" (San Diego, San Francisco, Las Vegas, Oklahoma City, and eight other cities with smaller numbers of mentions). The next largest contributor is western cities whose problems seem to be growing, at least by this measure, but the specific cities with apparently growing problems are somewhat different. In Figure 6, the five cities labeled as having "growing" problems are Dallas, Denver, Phoenix, San Antonio, and Seattle, with Phoenix accounting for 60% of the total and of the growth. Of these, only Seattle showed an upward trend in ED mentions. (ED data were not available for San Antonio.) For both ED and ME mentions, eastern cities constitute a small but growing share of all meth mentions, but for the ME data, almost all of the growth comes from a sudden and sustained increase from 2 to about 40 mentions in Long Island between 1998 and 1999. (Long Island is not a DAWN ED site.)

**Figure 6**
**Meth DAWN ME Mentions in 36 Cities, 1996-2001**

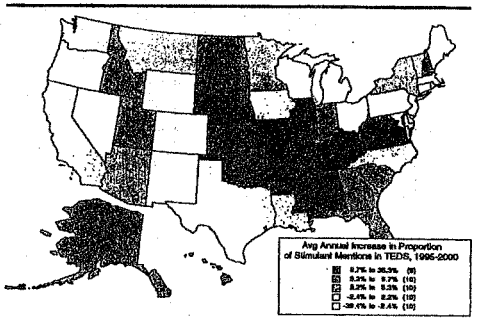



Treatment admissions information from the Treatment Episodes Dataset does not single out meth, but it does have a variable (STIMFLG) that pertains to mentions of stimulants generally. In light of the sometimes abrupt fluctuations in the total number of TEDS episodes from year to year, particularly at the state level, it is useful to focus on the proportion of TEDS cases mentioning stimulants. From 1995 to 2000, the states with the highest proportions of treatment episodes mentioning stimulants were in the West Coast/Rocky Mountain area, including Hawaii, plus Iowa and Oklahoma. (Figure not shown.)

Nationwide, this proportion of mentions involving stimulants grew at an average annual rate of 4.3% from 1995 to 2000. Figure 7 shows the state-by-state average annual *increases*.[14] (Data are missing for Arizona and West Virginia.) The map shows that the greatest percentage increases were in states in the Midwest and South-Central region; however, for the subset of these states that are east of the Mississippi (i.e., not Nebraska and Missouri), these percentage increases apply to quite low initial base, so even at the end of the period, none of these states had a proportion of treatment episodes involving stimulants that exceeded 5%. There is no evidence of penetration into the Northeast. Indeed, TEDS stimulant mentions were actually declining in much of the Northeast from the already low levels.



**Figure 7**
**State-by-State Average Annual Increase in Proportion of TEDS Mentions That Are for Stimulants, 1995-2000**




The final relevant indicator is the Arrestee Drug Abuse Monitoring (ADAM) system. Unfortunately, the biggest geographic hole in ADAM falls precisely in the block of states Figure 7 shows to have the sharpest increases in stimulant mentions in TEDS. Nevertheless, ADAM does have data on 40 cities and a unique ability to quantify the intensity of use, not just the prevalence or presence. Prevalence of use (technically, of the presence of metabolites) can be established objectively by urinalysis, but ADAM also asks respondents whether they have used a given substance in the last year and, if so, on how many days they used it. Self-report data concerning illegal activity is always somewhat dubious, and there is every reason to think that under-reporting could be an even greater problem when the respondents are sitting in a booking facility. With the possible exception of marijuana, however, it is not obvious why the extent of under-reporting necessarily varies greatly across substances. Hence, one can combine the answers to these questions to get a rough sense of the "market share" of meth, cocaine, and heroin, among all instances of use of one of these substances by criminally involved users. This population of respondents is of particular interest not only because of their criminal involvement, but also because they probably account for the vast majority of consumption of these substances (Kleiman, 1992; ONDCP, 2001b). Furthermore, these substances account for the majority of drug market spending (ONDCP, 2001b) and drug-related social problems (Caulkins et al., 2002).

To illustrate the computation, in Los Angeles the self-reported past-year prevalence for ADAM respondents (4th quarter, 2002) for meth, heroin, crack, and powder cocaine was 16.0%, 5.9%, 14.6%, and 7.1%, respectively.[15] Self-reported past year days of use for those reporting past-year use were 107, 30, 96, and 33, respectively. Multiplying associated pairs of these numbers suggests that the average numbers

of self-reported days of past-year use per arrestee in Los Angles were 17.2, 1.8, 7.0, and 3.3 for meth, heroin, crack, and powder, respectively. Again, the actual average number of days of use per arrestee could well be higher. If under-reporting is comparable across drugs, however, this suggests that meth accounted for 59% (17.2 / [17.2 + 1.8 + 7.0 + 3.3] = 59%) of all days of use of expensive illicit drugs by arrestees in Los Angeles.

Table 8 shows that by this measure, meth accounted for half or more of arrestees' consumption of expensive drugs in 12 of the 40 cities with ADAM data. (Shading of cells in the three right-hand columns indicates whether meth, cocaine, or heroin accounted for the plurality of self-reported consumption in the given city.) All 12 are west of the Mississippi. The largest meth "market share" east of the Mississippi was 4.6% in Indianapolis. Meth did not have a dominant market share in all cities west of the Mississippi. Meth's share was below 10% in four of the Texas locations, and no meth use was reported that quarter in Laredo.



**Table 8**
**ADAM Data for 40 Cities, Predominantly from the 4th Quarter of 2002: Shading in Right-Hand Columns Indicates Whether Meth, Cocaine (Crack + Powder Combined), or Heroin Accounted for the Plurality of Arrestees' Self-Reported Consumption of Expensive Illicit Drugs**

| | | % Testing Pos. for | Average Number of Days Used in Past Year | | | | | Share of Days of Use of "Expensive" Drugs (in %) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| City | Quarter | Meth | Meth | Crack | Powder Cocaine | Heroin | Marijuana | Meth | Cocaine | Heroin |
| Honolulu | Q4 '02 | 48.1 | 63.6 | 8.5 | 1.2 | 2.3 | 40.9 | 84 | 13 | 3 |
| San Diego | Q4 '02 | 36.5 | 41.2 | 11.1 | 3.2 | 10.5 | 46.5 | 63 | 22 | 16 |
| San Jose | Q4 '02 | 33.7 | 39.4 | 8.3 | 4.3 | 4.9 | 60.5 | 73 | 18 | 9 |
| Phoenix | Q4 '02 | 33.9 | 38.8 | 13.4 | 7.2 | 7.1 | 55.8 | 58 | 31 | 11 |
| Sacramento | Q4 '02 | 40.6 | 38.2 | 14.0 | 3.3 | 4.0 | 86.8 | 64 | 29 | 7 |
| Portland, OR | Q4 '02 | 25.0 | 31.3 | 20.3 | 13.0 | 24.5 | 42.4 | 33 | 37 | 27 |
| Spokane | Q4 '02 | 25.7 | 30.9 | 13.0 | 4.4 | 8.6 | 64.7 | 54 | 31 | 15 |
| Salt Lake City | Q4 '02 | 27.5 | 30.1 | 7.5 | 9.2 | 12.9 | 44.1 | 50 | 28 | 22 |
| Des Moines | Q4 '02 | 24.0 | 29.5 | 1.3 | 0.6 | 0.0 | 50.3 | 94 | 6 | 0 |
| Las Vegas | Q3 '02 | 21.1 | 27.1 | 23.1 | 8.0 | 2.1 | 49.3 | 47 | 50 | 4 |
| Oklahoma City | Q4 '02 | 14.4 | 23.7 | 16.0 | 6.8 | 1.3 | 62.3 | 50 | 48 | 3 |
| Tucson | Q4 '02 | 9.4 | 17.9 | 24.0 | 14.9 | 5.8 | 71.0 | 29 | 62 | 9 |
| Los Angeles | Q4 '02 | 14.4 | 17.2 | 7.0 | 3.3 | 1.8 | 46.2 | 59 | 35 | 6 |
| Tulsa | Q4 '02 | 16.0 | 16.4 | 12.5 | 1.7 | 0.0 | 84.3 | 54 | 46 | 0 |
| Seattle | Q4 '02 | 10.7 | 15.2 | 36.1 | 15.0 | 21.9 | 54.5 | 17 | 58 | 25 |
| Omaha | Q4 '02 | 21.4 | 11.3 | 20.3 | 4.4 | 0.0 | 57.8 | 31 | 69 | 0 |
| Woodbury City, MN | Q4 '02 | 8.9 | 10.6 | 2.3 | 1.7 | 1.9 | 45.9 | 64 | 24 | 31 |
| Albuquerque | Q4 '02 | 7.8 | 9.8 | 21.1 | 7.8 | 18.3 | 49.8 | 17 | 82 | 32 |
| Denver | Q4 '02 | 5.0 | 8.4 | 15.6 | 7.8 | 11.3 | 56.6 | 20 | 54 | 26 |
| Kansas City | Q4 '01 | 1.6 | 7.9 | 27.7 | 11.8 | 1.0 | 85.0 | 16 | 82 | 2 |
| Dallas | Q4 '02 | 3.4 | 5.0 | 11.5 | 10.2 | 4.7 | 65.5 | 16 | 69 | 15 |
| Anchorage | Q4 '02 | 1.2 | 4.4 | 15.7 | 8.1 | 0.0 | 53.0 | 16 | 86 | 0 |
| Minneapolis | Q4 '02 | 5.4 | 3.8 | 18.6 | 4.4 | 3.9 | 83.2 | 12 | 75 | 13 |
| Rio Arriba, TX | Q3 '02 | 0.0 | 2.7 | 16.3 | 24.0 | 51.5 | 50.7 | 3 | 43 | 55 |
| Indianapolis | Q4 '02 | 1.4 | 2.1 | 29.8 | 10.5 | 3.3 | 65.8 | 5 | 88 | 7 |
| San Antonio | Q4 '02 | 2.8 | 2.1 | 2.0 | 12.2 | 14.0 | 62.7 | 7 | 47 | 46 |
| Atlanta | Q4 '02 | 2.8 | 1.6 | 45.4 | 9.3 | 5.6 | 52.4 | 3 | 88 | 9 |
| Houston | Q2 '00 | 0.7 | 1.0 | 13.5 | 8.1 | 1.6 | 55.7 | 4 | 89 | 7 |
| Albany, NY | Q4 '02 | 0.0 | 0.9 | 15.9 | 8.2 | 11.4 | 86.6 | 2 | 66 | 31 |
| Birmingham | Q4 '02 | 0.0 | 0.9 | 23.3 | 11.6 | 1.6 | 60.9 | 2 | 94 | 4 |
| New Orleans | Q4 '02 | 2.2 | 0.6 | 29.6 | 11.6 | 22.0 | 72.9 | 1 | 65 | 34 |
| Chicago | Q4 '02 | 0.4 | 0.5 | 38.9 | 3.6 | 1.7 | 80.2 | 1 | 95 | 4 |
| Washington, DC | Q4 '02 | 0.0 | 0.4 | 11.3 | 6.7 | 9.4 | 61.7 | 2 | 64 | 34 |
| Cleveland | Q4 '02 | 1.2 | 0.2 | 20.0 | 9.9 | 0.3 | 75.4 | 1 | 98 | 1 |
| Philadelphia | Q3 '02 | 0.0 | 0.2 | 28.2 | 10.8 | 22.8 | 95.8 | 0 | 63 | 37 |
| Charlotte, NC | Q4 '02 | 0.0 | 0.1 | 33.8 | 4.7 | 34.9 | 84.3 | 0 | 52 | 48 |
| New York City | Q4 '02 | 0.3 | 0.0 | 45.2 | 16.7 | 28.4 | 68.7 | 0 | 69 | 31 |
| Detroit | Q4 '01 | 0.0 | 0.0 | 15.0 | 3.0 | 5.3 | 71.7 | 0 | 77 | 23 |
| Ft. Lauderdale | Q2 '00 | 0.0 | 0.0 | 13.0 | 6.3 | 1.7 | 52.9 | 0 | 92 | 8 |
| Laredo | Q3 '02 | 0.0 | 0.0 | 3.6 | 12.9 | 11.6 | 23.0 | 0 | 59 | 41 |
| Simple Average | | 9.1 | 13.4 | 18.3 | 8.0 | 9.4 | 61.9 | 26 | 57 | 17 |

## Discussion

The characteristics of the spatial diffusion of meth are not yet well understood, but four statements can be made with a high degree of certainty: (1) Meth use can grow very quickly, with indicators sometimes growing by 20% or more per year for a number of years in specific cities, (2) Meth use can reach very high levels; it appears to be responsible for the majority of criminals' days of use of expensive

illicit drugs in a dozen ADAM cities, (3) A substantial proportion of the nation's population lives in regions that meth has essentially not yet reached, (4) Meth is spreading geographically into regions that previously had little meth use.

Together those four statements might seem to be cause for considerable alarm. They do not necessarily imply an impending disaster, however, for two reasons. The less important counter-argument is that the high levels of meth use in a city or region may not be sustained for an extended period, so even if the problem becomes acute in additional regions, those problems might subsequently ebb moderately quickly. Whether that is the case remains an unanswered empirical question, but the ED and ME data for Los Angeles and San Diego are not encouraging in this regard.

The second possible counter-argument is that use may stabilize at levels well below those in Los Angeles or San Diego. The best available evidence concerning this possibility comes from the 17 cities with multiple indicators at reasonably high levels. More specifically, the cities selected were those with data for at least two of the four indicators (DAWN ED, DAWN ME, TEDS, and ADAM) and TEDS stimulant mention proportions averaging at least 3%, plus Philadelphia (important because it is the only East Coast city with a long history of meth abuse) and Phoenix (no TEDS data, but very high levels on the other three indicators). Also, San Jose is paired with San Francisco because it is so close and because it does not have its own DAWN data.

For each of these cities, Table 9 shows recent average levels and average annual growth rates for DAWN ED mentions (1995 – 2001), DAWN ME mentions (1996 – 2001), and the proportion of TEDS episodes mentioning stimulants (1995 – 2000). The cities are rank ordered in terms of descending average of these growth rates (given in the second to last column), where the average includes the DAWN ME growth rate only if the average number of ME mentions is at least 20[17] [e.g., Phoenix' 12% average = (-7% + 13%) / 2]. Finally, the last column gives meth's "market share" in the ADAM data (from Table 8).

The key insight from Table 9 is that even leaving Denver aside, ten of the remaining fifteen cities had average meth problem indicator growth rates of 2% or less. Four of these ten cities with "stable" meth problems stabilized at very high levels of use (Las Vegas, Los Angeles, Oklahoma City, and San Diego). Furthermore, if one assumes San Jose's market share is indicative of what San Francisco's would be if it were an ADAM site, then San Francisco would also be part of this group; however, three of the ten (Atlanta, Philadelphia, and San Antonio) stabilized with meth market shares of 0.3% to 7%. The remaining two "stabilized" cities, Dallas and Portland, have intermediate meth market shares of 16% and 35%, respectively.



**Table 9**
**Meth Problem Growth Rates and Recent "Market Share" Among Arrestees' Use of Expensive Illicit Drugs for Cities with Best Meth Data**

| | DAWN ED (95-01) | | DAWN ME (96-01) | | TEDS Prop. (95-00) | | Avg. Growth Rate | ADAM (-02) |
|---|---|---|---|---|---|---|---|---|
| | Level | Growth Rate | Level | Growth Rate | Level | Growth Rate | | Market Share |
| Phoenix | 613 | -7% | 73 | 31% | | | 12% | 56% |
| Omaha | | | 6 | 12% | 16% | 10% | 10% | 31% |
| Salt Lake City | | | 15 | 4% | 23% | 10% | 10% | 50% |
| Minneapolis | 159 | 15% | 5 | 4% | 8% | 0% | 8% | 12% |
| Seattle | 395 | 10% | 11 | 22% | 13% | 5% | 7% | 17% |
| Kansas City | | | 15 | -9% | 10% | 5% | 5% | 16% |
| San Antonio | | | 8 | 20% | 6% | 2% | 2% | 7% |
| Los Angeles | 1194 | 2% | 146 | 0% | 13% | 5% | 2% | 59% |
| Oklahoma City | | | 49 | -5% | 20% | 8% | 2% | 50% |
| Las Vegas | | | 50 | 0% | 29% | 3% | 1% | 47% |
| San Diego | 722 | -1% | 98 | 0% | 38% | -1% | -1% | 63% |
| Atlanta | 146 | -3% | 3 | 51% | 3% | 0% | -1% | 3% |
| Portland, OR | | | 9 | 3% | 20% | -1% | -1% | 35% |
| Dallas | 144 | -9% | 18 | 21% | 12% | 0% | -4% | 16% |
| San Francisco | 775 | -12% | 46 | -4% | 15% | 1% | -5% | |
| San Jose | | | | | 44% | 6% | | 73% |
| Philadelphia | 69 | -8% | 10 | -27% | 2% | -9% | -8% | 0% |
| Denver | 143 | -10% | 8 | 34% | 4% | | | 20% |

More generally, in these cities with the best data, of the three growth indicators, the one typically growing the fastest is the DAWN ME mentions. DAWN ED mentions are growing most slowly, and TEDS growth is intermediate. It is perhaps possible that ME mentions are something of a trailing indicator of epidemic growth, with many deaths attributable to long-time chronic users. Some ED mentions are similar, but others can include adverse reactions from inexperienced users.[18] It would be useful in subsequent work to obtain the original data tapes and break down these time series by age of respondent and reason for ED visit.

It is possible then to look at these city-specific trends in a way that gives grounds for cautious optimism regarding the future. *If* the epidemic really has peaked in the western cities that accounted for most of the mentions over the last decade and *if* eastern cities continue to be largely immune to the meth epidemic, then subsequent increases may be confined to the Midwest and South-Central regions. Furthermore, use in cities where meth is still growing (e.g., Kansas City) could possibly stabilize at levels more like what pertains now in San Antonio, rather than San Diego.

Those are very big "*ifs*," however. It is entirely possible that meth use could grow even in cities where it has been common and stable for some time. (Los Angeles' ED figures for 2001 are troubling in this regard.) It is possible that Kansas City's use levels will rise to those of Oklahoma City, if not San Diego, and it is entirely possible that meth will continue its march east, with sharp increases in use next being recorded in cities such as Chicago and Detroit, which heretofore have seen little use.

The future, as always, is uncertain. Nevertheless, this detailed look at the data does clarify some things. For instance, while it is true that recent years have seen large percentage increases in some indicators in some cities, since the mid-1990s those increases have mostly been confined to cities that are small- to medium-sized and/or had a small problem to begin with. The overall national counts have been dominated by what happens on the West Coast and in the Rocky Mountain regions, where meth use seems to have stabilized. Furthermore, not all areas with historically low rates of use are seeing these sharp percentage increases. Hence, it is possible to reconcile the three simultaneous images of stable national data, alarm at sharp increases in some regions, and a frustration in other regions with repeated dire warnings that have not been followed by any increase in use.

Several policy prescriptions emerge from this somewhat complex and nuanced view. Further disaggregation and analysis of these existing data is worthwhile, particularly looking at patterns in specific demographic groups in specific locations (one might wish to look separately at trends in DAWN and TEDS data for younger cohorts). Likewise, the new state-level indicators in the NHSDA could be utilized.

Meth is a large enough and dynamic enough problem that data collection instruments should be modified. DAWN, ADAM, and the NHSDA single out meth, but TEDS and Monitoring the Future ask only about stimulants. UCR arrest data are even less useful.

Those recommendations pertain to further research, but what if any action should be taken today? There is good reason to think that law enforcement is particularly effective during the initial, rapid growth stages of a drug epidemic. There is clear evidence that some specific regions of the country are in those early stages. There is some possibility, though by no means certainty, that this currently regional phenomenon of rapid growth will spread to the populous eastern seaboard. Hence, it would seem prudent to target additional enforcement resources at meth distribution in those specific regions where its use appears to be growing quickly. Presumably, local and state law enforcement agencies in these regions are already doing their utmost to confront the spread of meth. It may, however, make sense for agencies with a national purview, notably DEA and FBI, to shift some of their efforts from more stabilized markets (e.g., for cocaine generally or perhaps meth on the West Coast) into regions where meth is making rapid inroads.

## References


Agar, M. H., & Wilson, D. (2002). Drugmart: Heroin epidemics as complex adaptive systems. *Complexity, 7*(5), 44-52.

Bass, F. M. (1969). A new product growth model for consumer durables. *Management Science, 15*(5), 215-227.

Behrens, D., Caulkins, J. P., Tragler, G., Haunschmied, J. L., & Feichtinger, G. (1999). A dynamic model of drug initiation: Implications for treatment and drug control. *Mathematical Biosciences, 159*, 1-20.





Behrens, D., Caulkins, J., Tragler, G., & Feichtinger, G. (2000). Optimal control of drug epidemics: Prevent and treat—but not at the same time? *Management Science, 46*(3), 333-347.

Behrens, D. A., Caulkins, J. P., Tragler, G., & Feichtinger, G. (2001). Why present-oriented societies undergo cycles of drug epidemics. *Journal of Economic Dynamics and Control, 26*(6), 919-936.

Behrens, D., Caulkins, J. P., & Tragler, G. (2002). *A dynamic game of two regions with interacting drug epidemics.* Paper presented at the 10th International Symposium on Dynamic Games, St. Petersburg, Russia.

Bell, D. S., & Champion, R. A. (1977). The dynamics of trends in drug use in Australia. *Bulletin on Narcotics, 29*(3), 21-31.

Brill, H., & Hirose, T. (1969). The rise and fall of a methamphetamine epidemic: Japan 1945-55. *Seminars in Psychiatry, 1*(2), 179-194.

Bushway, S. D., Caulkins, J. P., & Reuter, P. In Submission. Does state and local drug enforcement raise retail cocaine prices?

Caulkins, J. P. (2000). *Should the U.S. direct more law enforcement effort at XTC?* CT-171, (Statement submitted to Subcommittee on Crime of the House Committee on the Judiciary, June 15th, 2000). Santa Monica, CA: RAND.

Caulkins, J. P. (2001). The dynamic character of drug problems. *Bulletin of Narcotics, 53*(1), 11-23.

Caulkins, J. P. (2002). Law enforcement's role in a harm reduction regime. In *Crime and Justice Bulletin, 64*. New South Wales: Bureau of Crime and Justice Research.

Caulkins, J. P. (Forthcoming). Drug policy: Insights from mathematical analysis. In P. Sainfort, W. Pierskalla, & M. Brandeau (Eds.), *Handbook of OR/MS applications in healthcare.*

Caulkins, J. P., Paddock, S., Pacula, R., & Chiesa, J. (2002). *School-based drug prevention: What kind of drug use does it prevent?* Santa Monica, CA: RAND.

Caulkins, J. P., & Reuter, P. (1998). What price data tell us about drug markets. *Journal of Drug Issues, 28*(3), 593-612.

Cunningham, J. K., & Liu, L. M. (Forthcoming). Impacts of federal ephedrine and pseudoephedrine regulations on methamphetamine-related hospital admissions. *Addiction.*

Drug Availability Steering Committee. (2002). *Drug availability estimates in the United States.* (NCJ Document NCJ-197107). Washington, DC: U.S. Government Printing Office.

# NATIONAL SYNTHETIC DRUGS ACTION PLAN

*The Federal Government Response to the Production, Trafficking, and Abuse of Synthetic Drugs and Diverted Pharmaceutical Products*

# NATIONAL SYNTHETIC DRUGS ACTION PLAN

*The Federal Government Response to the Production, Trafficking, and Abuse of Synthetic Drugs and Diverted Pharmaceutical Products*

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

October 2004

The United States faces an array of drugs of abuse. Many, such as cocaine, heroin, and marijuana have confronted us for decades. We have developed programs and initiatives to combat these drugs—to prevent use, treat the addicted, and disrupt production and the marketplace for drugs. The significant threat to the nation posed by synthetic drugs, especially methamphetamine and MDMA, or "Ecstasy," is a more recent phenomenon. Initial efforts to confront synthetic drugs are already showing results. As demonstrated by the findings of the most recent National Survey on Drug Use and Health (formerly known as the National Household Survey on Drug Abuse) and the 2003 Monitoring the Future study, when we collectively push back, the synthetic drugs threat also will decline.

A related threat is the growth in nonmedical use of pharmaceutical controlled substances. Diversion of these legitimate drugs is fueled in part by easy access over the Internet. The most recent NSDUH and other data indicate that we continue to confront increased use of such drugs, notably pain relievers and tranquilizers. This document recommends some new approaches to address this challenge.

This Action Plan is designed both to convey the seriousness of the challenges posed by synthetic drugs and diverted pharmaceuticals and to outline specific steps the federal government will take in the future to capitalize on recent successes and accelerate our national efforts against these harmful substances. Through the recommendations in this Action Plan and with the active engagement of our partners in state and local government, we intend to move aggressively in the coming years. To facilitate follow-up, this Action Plan creates a high-level interagency working group to ensure that these recommendations are implemented as effectively and rapidly as possible.

This document is a product of the hard work of the Department of Justice Criminal Division's Narcotic and Dangerous Drug Section, in cooperation with the Drug Enforcement Administration and several other agencies, and in consultation with various components of the Department of Health and Human Services. We are grateful for their efforts. The Action Plan represents an important step forward in our nation's effort to control dangerous synthetic drugs and pharmaceutical products and, moreover, in the continued achievement of the objectives set forth in the President's National Drug Control Strategy.

John P. Walters
Director
Office of National Drug Control Policy

John Ashcroft
Attorney General

# Table of Contents

I. Overview
A. Introduction ..... 1
B. Plan for Implementation of Recommendations ..... 2
C. List of Recommendations ..... 3
1. Prevention ..... 3
2. Treatment ..... 4
3. Regulation of Chemicals and Drugs ..... 4
4. Law Enforcement ..... 6

II. Nature of the Problem ..... 11
A. Consumption Trends ..... 11
1. Methamphetamine ..... 11
2. MDMA/Ecstasy ..... 14
3. Other Club Drugs ..... 16
4. Other Synthetic Drugs and Diverted Pharmaceuticals ..... 17
B. Trafficking Trends ..... 19
1. Methamphetamine ..... 19
2. MDMA/Ecstasy ..... 23
3. Other Club Drugs ..... 24
4. Other Synthetic Drugs and Diverted Pharmaceuticals ..... 25

III. Response to the Problem ..... 27
A. Prevention ..... 27
1. Current Efforts ..... 27
2. Recommendations ..... 29
B. Treatment ..... 30
1. Current Efforts ..... 30
2. Recommendations ..... 31
C. Regulation of Chemicals and Drugs ..... 31
1. Current Efforts ..... 31
a. Introduction ..... 31
b. U.S. Chemical Controls ..... 33
c. The International Challenge ..... 35
d. Chemical Control Results ..... 37
e. Control of OxyContin and Other Diverted Pharmaceutical Products ..... 38
2. Recommendations ..... 39
D. Law Enforcement ..... 41
1. Current Efforts ..... 41
a. Methamphetamine: Planning and Coordination ..... 41
b. MDMA: Planning and Coordination ..... 42
c. Training ..... 43
d. Seizures, Investigations, and Prosecutions ..... 43
2. Recommendations ..... 44

Appendices
A. Outline of an Early Warning and Response System for Emerging Drugs of Abuse ..... 49
B. Overview of the New Drug Abuse Warning Network (DAWN) System Design & Implementation ..... 53
C. DEA Action Plan to Prevent the Diversion and Abuse of OxyContin ..... 55
D. Schedules and Regulatory Controls Applicable to the Subject Controlled Substances ..... 59
E. Sentencing ..... 63
F. Examples of Notable State Laws with Respect to Precursor Chemical Control ..... 67

# I. Overview

## *A. Introduction*

The illicit production of synthetic drugs is hardly a new problem in this country. For years, community leaders and law enforcement officials have understood the threat and expressed concern for the future based on the potential dangers of these drugs.

That uncertain future is now a disturbing reality. In the past five years, the use of synthetic drugs has climbed dramatically, a fact that lends urgency to the effort to control them. Recent drug-consumption studies indicate that substantial numbers of Americans are using these harmful substances. While the use of MDMA has fallen off significantly among young people in the last two years, its use remains at unacceptable levels. The gradual expansion in the use of methamphetamine may be continuing as well. These two drugs pose the most significant synthetic drug threats to the nation.

The expansion in the demand for these drugs is not limited to the United States. Several countries in Europe and Asia are similarly challenged by the spread of the synthetic drug trade. Encouraged and emboldened by the growing global demand for these drugs, traffickers are exploiting every available opportunity to produce, export, and market a wide variety of synthetic drugs. A large volume of precursor chemicals and synthetic drugs produced overseas is now smuggled into the United States to support domestic production and distribution as well.

The purpose of this document is to provide a blueprint for action under the President's National Drug Control Strategy that brings together the various strands of domestic and international efforts into a coherent plan for attacking and disrupting the trade in these dangerous drugs. This Action Plan focuses on illicitly manufactured synthetic drugs, including methamphetamine, amphetamine, MDMA, GHB, PCP, and LSD, which are not of primarily organic origin. It also discusses selected pharmaceutical products which are sometimes diverted from legitimate commerce, such as ketamine and oxycodone (particularly in the form of OxyContin), and the illegally imported depressant flunitrazepam (trade name Rohypnol). Regardless of the venues in which they are used, the problems posed by licitly produced pharmaceutical products are distinct from those pertaining to clandestinely produced drugs, and the approaches to prevent their illegal trafficking likewise vary.

Methamphetamine is the most widely used and clandestinely produced synthetic drug in the United States and, thus, receives the most attention in this Action Plan. Although methamphetamine is manufactured licitly for medical purposes, the vast majority of illegally trafficked methamphetamine is produced illegally in laboratories both here and abroad. The related synthetic stimulant amphetamine is typically trafficked interchangeably with methamphetamine and produced clandestinely by a similar process, and it has a similar effect on users.

While all of the drugs discussed in this paper are significant drugs of abuse, some of these substances—namely MDMA ("Ecstasy"), GHB, Rohypnol, and ketamine—are distinguished as "club drugs" because they are commonly encountered at nightclubs and late-night dance parties called "raves" or "circuit parties."[1] MDMA (3,4-methylenedioxymeth-amphetamine) is a stimulant with

hallucinogenic properties that has surged in use in recent years. Gamma hydroxybutyric acid (GHB) and Rohypnol are depressants which are often used to incapacitate victims in sexual assaults; the instances of GHB use are increasing, while trafficking in Rohypnol appears to be decreasing.[2] Ketamine is a dissociative anesthetic which has also become popular among rave and circuit party attendees. Furthermore, there is a virtual alphabet soup of "designer drugs" that are not frequently encountered by law enforcement, but which may proliferate at raves and other youth-oriented settings at any time.

Additionally, the use of synthetic opiates, especially oxycodone, is growing, and the dissociative anesthetic phencyclidine (PCP) is still being used. The hallucinogen lysergic acid diethylamide (LSD) has seen major declines in youth use—to the lowest levels since surveys began in 1975. None of these drugs, however, is commonly associated with raves and circuit parties.

Synthetic drugs not only harm the bodies and minds of those who use them, they also threaten human health through the damage they inflict on the environment. For example, the process of making methamphetamine requires the use of hazardous chemicals, many of them flammable, corrosive, or explosive. Moreover, methamphetamine is made primarily by unscrupulous chemists, often operating in makeshift labs, with little regard for public safety or environmental health. Methamphetamine labs produce toxic byproducts that commonly end up in fields, public parks, and waterways. Some of these chemicals can cause disfigurement, illness, or even death on contact.[3]

As discussed in the National Drug Control Strategy, synthetic drugs by their very nature present special challenges to the agencies and organizations working to stop them. Because the drugs are made in laboratories and not harvested from fields, there are no crops to eradicate as in the cases of marijuana, heroin, and cocaine. Instead, supply reduction efforts must focus on limiting access to precursor chemicals, shutting down illegal labs, and breaking up organized criminal groups that manufacture and distribute the drugs. We need to strengthen international and domestic law enforcement mechanisms, emphasizing informal, flexible, and rapid communications at the operational level. Like the traffickers who fuel the market, we must ourselves become more nimble, developing policies and methods that allow us to adapt quickly and seize every opportunity to disrupt the trade.

This Action Plan begins with a general outline of demand and trafficking trends with respect to the drugs highlighted above. Next, it discusses the status of prevention, treatment, regulatory and law enforcement efforts, and provides recommendations for future actions in each of these areas. The Action Plan also includes six appendices. Appendix A is a proposed outline for an early warning and response system to identify and address the impact of emerging drugs of abuse. Appendix B provides an overview of the new Drug Abuse Warning Network (DAWN) system design and implementation plans. Appendix C is a Drug Enforcement Administration (DEA) Action Plan to Prevent the Diversion and Abuse of OxyContin. Appendix D outlines the schedules and regulatory measures that apply to the subject controlled substances and their chemical precursors. Appendix E summarizes the applicable sentencing guidelines. Appendix F summarizes precursor chemical control laws in Missouri and Oklahoma.

### *B. Plan for Implementation of Recommendations*

Overarching responsibility for implementing the recommendations in this Action Plan will reside in a new Synthetic Drugs Interagency Working Group (SD-IWG), to be co-chaired by the Office of National Drug Control Policy and the Department of Justice. The SD-IWG can, at the discretion of

the co-chairs, refer recommendations to other pre-existing government working groups. The SD-IWG will meet within 30 days of the publication of this report, and thereafter on an as-needed basis. The group will submit a written implementation update to the Director of the Office of National Drug Control Policy and the Attorney General six months after publication of this Action Plan.

## *C. List of Recommendations*

1. Prevention

**Develop an Early Warning and Response System** - (**NDIC**, DOJ, HHS, ONDCP)
Establish a comprehensive, interagency, early warning and response system to detect the emergence of new drugs and trends. Appendix A lays out the possible parameters of such a system in detail, but it should include increased research efforts to develop and disseminate accurate, reliable, and cost-effective tests for identifying new synthetic drug use trends. Particular focus should be given to earlier identification and routine detection of licitly produced drugs with high illicit use potential.

**Enhance Public Outreach Efforts Focusing on Synthetic Drugs** - (**SAMSHA**, DOJ, ONDCP)
Develop a multimedia education campaign on the consumption of synthetic drugs, focusing initially on methamphetamine. The program should, as appropriate, incorporate messages about the environmental threat and risks to children from clandestine labs. Ensure adequate dissemination of all pertinent materials and information on synthetic drugs through the Department of Education's Office of Safe and Drug-Free Schools.

**Improve Education and Training on Pharmaceuticals** - (**DEA**, FDA, SAMHSA, ONDCP)
Ensure product labeling that clearly articulates conditions for the safe and effective use of controlled substances, including full disclosure of safety issues associated with pharmaceuticals. Develop a mechanism for the wider dissemination and completion of approved Continuing Medical Education courses for physicians who prescribe controlled substances. Develop Internet public service announcements regarding the potential dangers and illegality of online direct purchase of controlled substances.

**Develop Best Practices to Assist Drug-Endangered Children** - (**HHS**, EPA, DOJ, DEA, ONDCP)
Develop protocols for assisting drug-endangered children that generally address staff training; roles and responsibilities of intervening agencies; appropriate reporting, cross reporting, information sharing, and confidentiality; safety procedures for children, families, and responding personnel; interviewing procedures; evidence collection and preservation procedures; medical care procedures; and community resource development.

**Research and Develop Targeted Prevention Programs** - (**NIDA**, ONDCP)
Support research on the initiation of methamphetamine use and the progression of use leading to addiction. Programs should be developed to target high-risk groups or communities and to increase community involvement in prevention efforts.

**Improve Data on Afflicted Geographic Areas** - (**NDIC**, SAMHSA, DOJ, ONDCP)
Build on existing Geographical Information System (GIS) resources and databases to integrate federally mandated drug test results, crime laboratory evidence analysis, population demographics, and

other meaningful data pertaining to synthetic drugs and diverted pharmaceuticals in a manner that supports geographically based prevention and intervention efforts.

**Examine the Use of Prescription Narcotics** - (**NIDA**, SAMHSA, FDA, NIJ, DEA)
Assess the scope and magnitude of the licit and illicit use of prescription narcotic analgesics, in particular OxyContin, including the pursuit of additional data sources in cooperation with the Food and Drug Administration (FDA), the National Institute for Justice (NIJ), private entities, and others.

2. Treatment

**Increase Treatment Capacity** - (**HHS**)
Assess treatment needs for synthetic and diverted pharmaceutical drug addiction and, if necessary, expand that capacity in the community and in correctional facilities. Particular emphasis should be given to the development of additional treatment capacity for methamphetamine users, to include follow-up services that address the protracted recovery period associated with methamphetamine dependency.

**Research Treatment for Synthetic Drug Abuse** - (**HHS**, NIDA, SAMHSA, ONDCP)
Increase research on the physical and psychological effects of methamphetamine and other synthetic drugs, as well as on the development of effective treatment protocols for synthetic drugs.

**Develop Guidelines for Juvenile Drug Treatment** - (**NIDA**, SAMHSA)
Fund research on and pursue the development of guidelines with respect to the treatment of juveniles, who often are not adequately served in existing drug treatment programs designed for adults.

**Develop Early Response Treatment Protocols** - (**NIDA**, SAMHSA)
Develop and disseminate early-response protocols addressing requests for treatment of dependency on emerging synthetic drugs and diverted pharmaceuticals.

**Study Options for Criminal Justice System Treatment** - (**NIDA**, SAMHSA, NIJ)
Invest in additional studies on the efficacy of various comprehensive treatment programs for synthetic drug abuse and on their adaptability to diverse individual and community needs, especially those unique to the criminal justice system.

**Expand Dissemination of Treatment Best Practices** - (**NIDA**, SAMHSA, ONDCP, DEA)
Expand capabilities to disseminate pertinent research results and best-practices training techniques as part of the overall effort to increase access to effective treatments for dependencies on synthetic and diverted pharmaceutical drugs.

3. Regulation of Chemicals and Drugs

**Support Stronger State Controls on Precursor Chemicals** - (**DOJ**, ONDCP, DEA)
States that face significant levels of clandestine lab activity and chemical diversion are urged to consider the imposition of more stringent controls than those currently in place at the federal level. Several states, notably Oklahoma, have recently enacted strict retail-level controls. (See Appendix F). Additional state-level controls could include, for example: allowing only licensed pharmacists and pharmacy technicians to sell products containing precursor chemicals; placing such products behind the sales counter and/or in a locked display case; purchase limits imposed on a transaction

and/or monthly basis (with an appropriate tracking mechanism); and requirements of customer identification sales record keeping.

**Remove the Blister Pack Exemption** - (**DEA**, DOJ)
Support legislation that removes the blister pack exemption and eliminates distinctions based on the form of packaging, as recommended in DEA's November 2001 report to Congress.

**Regulate Chemical Spot Market** - (**DEA**, DOJ)
As an extension of existing authority over imports, law enforcement should seek the legislative authority to regulate sales of bulk chemicals on the domestic spot market by notification and approval of any deviations in quantity or customer from the import declaration.

**Determine Licit Chemical Needs** - (**DEA**, DOJ, ONDCP)
In cooperation with industry, commission a statistical analysis to estimate the legitimate needs for pseudoephedrine and ephedrine products—including combination products such as ephedrine with guaifenesin—both nationwide and regionally.

**Enable Import Controls on Bulk Ephedrine and Pseudoephedrine** - (**DEA**, DOJ, ONDCP)
Seek legislation that would treat the post-importation handling of bulk ephedrine and bulk pseudoephedrine in a similar manner, for regulatory purposes, as federal laws now treat the post-importation processing of Schedule I and II controlled substances. Impose such controls on these critical precursors as are needed to limit imports to those necessary for legitimate commercial needs and for maintenance of effective control over chemical diversion.

**Limit Online Chemical Sales** - (**DEA**, DOJ)
Continue ongoing efforts to advise the owners and operators of major on-line auction websites of the use of precursor chemicals in clandestine labs, and urge them to consider banning the sale of precursor chemicals over their websites.

**Strengthen Cooperation with Mexico** - (**DEA**, DOJ, State, ONDCP)
Solidify significant recent advancements by Mexico to increase the effectiveness of bilateral chemical control with the United States through continued partnership and meetings with the pertinent Mexican components, including their drug intelligence center (CENAPI), the Federal Investigative Agency (AFI), the chemical regulatory entity in the Ministry of Health (COFEPRIS), and the Health Commission.

**Enhance Coordination and Information Exchange with Canada** - (**DHS**, ICE, CPB, DEA)
Enhance ongoing coordination with Canada Customs and Revenue Agency on border detection, targeting, and interdiction efforts, and ensure appropriate focus by Canada-U.S. joint Integrated Border Enforcement Teams on the precursor chemical and synthetic drug threats. Further expand the ongoing exchange of information concerning Canadian businesses involved in the importation, production, and distribution of pseudoephedrine—particularly those firms whose products have frequently been diverted or smuggled into the United States.

**Strengthen the Multilateral Chemical Control System** - (**DEA**, DOJ, State, ONDCP)
Garner international support for making existing multilateral chemical controls more universal, formal, and well-supported by international institutions, including UN bodies such as the International

Narcotics Control Board and regional bodies such as the Organization of American States' Inter-American Drug Abuse Control Commission (CICAD). Work to realize the full potential of Project PRISM, and build support for the application of the 1988 UN Convention to pharmaceutical preparations containing precursor chemicals that can be easily recovered for use in illicit drug production.

**Exchange Information with Chemical Producing Countries** - (**DEA**, DHS, State, USTR)
Continue ongoing information-sharing efforts with the countries that produce precursor chemicals used to make amphetamine-type stimulants, particularly China, India, Germany, and the Czech Republic.

**Educate Store Employees** - (**DEA**, DOJ)
Building on efforts begun in a number of states, work to develop a model training program for pharmacists, retail management, and store employees concerning suspicious pseudoephedrine purchases, as well as suspicious sales of chemicals and items used in the manufacture of methamphetamine.

**Encourage Voluntary Controls by Retail Pharmacies and Stores** - (**DEA**, DOJ, ONDCP)
Seek the voluntary participation of major retail chains in programs to control pseudoephedrine products through restrictions on the quantity that can be purchased at a single time. Also support the voluntary movement of pseudoephedrine products from stores' open shelves to behind pharmacy counters or other manned counters in retail settings where pharmacies are not on site.

**Work with Manufacturers to Reformulate Abused Pharmaceutical Products** - (**DEA**, FDA)
Continue to support the efforts of firms that manufacture frequently diverted pharmaceutical products to reformulate their products so as to reduce diversion and abuse. Encourage manufacturers to explore methods to render products containing key precursors such as pseudoephedrine ineffective in the clandestine production of methamphetamine and pain control products such as OxyContin less suitable for snorting or injection.

**Support State Prescription Monitoring Programs** - (**DEA**, ONDCP)
Support states' creation of prescription monitoring programs designed to detect inappropriate prescribing patterns and prescription fraud. Law enforcement and regulatory entities should have access to information in case of apparent diversion or inappropriate prescribing of controlled substances, and some provision for state-to-state communication of adverse information should be examined. Supporting legislation should be explored.

4. Law Enforcement

**Target Pseudoephedrine and Iodine Smuggling to and from Mexico** - (**DEA**, ICE, CBP)
Focus law enforcement resources on stopping the recently-noted flow of suspicious shipments of precursor chemicals, notably pseudoephedrine, from Asia to Mexico, apparently destined for clandestine methamphetamine labs in Mexico and the United States. Also focus on the smuggling of iodine from Mexico. In all such cases, law enforcement should identify and aggressively pursue the persons and firms responsible.

**Focus on Canadian Synthetics and Chemical Smugglers** - (**DEA**, ICE, DOJ)
Expand joint U.S.-Canadian investigations into the smuggling of chemicals, methamphetamine, MDMA, and other club drugs and diverted pharmaceuticals. Assign high priority to investigations of

large seizures of pseudoephedrine and ephedrine from Canada, and develop prosecutable cases against rogue Canadian companies and their principals.

**Investigate Ties between Canadian and Mexican Criminals -** (**DOJ**, DEA, ICE, NDIC)
Analyze law enforcement reporting and intelligence with respect to Canadian pseudoephedrine and ties between Canadian sellers and Mexican lab operators in California. Analysis of the flow of funds generated from sales of pseudoephedrine in Canada and the United States should be coordinated by the appropriate agencies within the concerned Departments.

**Investigate Asian and European Sources of Synthetic Drugs -** (**DEA**, ICE, State)
Work with international law enforcement partners and regional groups to investigate Asian criminal groups in North America and in Asia that increasingly may be engaged in producing and trafficking synthetic drugs and their precursor chemicals. Enhance bilateral efforts with the Netherlands and other MDMA-producing countries in Europe to build investigations, share information, and extradite criminals where appropriate.

**Enhance Methamphetamine Profiling Efforts -** (**DEA**, DOJ, ONDCP)
Increase the number of samples available for analysis in DEA's methamphetamine profiling program by incorporating samples of the drug seized by state and local law enforcement at super labs, or from shipments strongly suspected of originating from such large-scale operations. Also leverage information on chemicals, adulterants, cutting agents, and equipment found at the site.

**Review Lab Cleanup Resources -** (**DEA**, DOJ, EPA)
Ensure adequate funding sources for clandestine laboratory and dumpsite cleanups, including funding for sufficient personnel to support laboratory cleanups and hazardous waste disposal, so that cleanup costs are not a disincentive to laboratory investigations or takedowns. Federal officials, in collaboration with state agencies, should conduct a needs assessment to identify potential program improvements and make recommendations on the specific support needed and the funds required.

**Apply Updated Clandestine Lab Cleanup Guidelines -** (**DEA**, EPA)
Disseminate and apply the latest guidelines for the cleanup of clandestine methamphetamine labs and, where necessary, coordinate environmental remediation by appropriate entities. These protocols for adulteration and destruction of precursor and essential chemicals, glassware, and methamphetamine waste should be part of clandestine laboratory certification training.

**Increase Prosecutor and LEA Training -** (**DOJ**, DEA, CBP)
Recognizing the unique issues presented by chemical and methamphetamine cases, the Federal Government should, as resources permit, offer training for criminal and civil prosecutors and federal, state, and local law enforcement agents more frequently and in different regions of the country.

**Make Full Use of Charging and Sentencing Options -** (**DOJ**, DEA)
Prosecutors should make full use of federal Sentencing Guidelines provisions, which set a sentencing floor (of 70-87 months) for any case involving methamphetamine manufacture that creates a substantial risk of harm to human life. Federal prosecutors should also make greater use of the environmental enhancement for clandestine drug manufacturing involving "unlawful discharge, emission, or release into the environment of a hazardous or toxic substance or for the unlawful transportation, treatment, storage, or disposal of a hazardous waste."

**Increase Access to Civil Penalty Case Experts** - (**DOJ**)
The Department of Justice should develop and disseminate a list of attorneys who have experience in civil penalty cases under the Controlled Substances Act and who are available to assist U.S. Attorney's Offices in districts where such cases have never or rarely been referred or pursued.

**Prevent Exploitation of Mail Services** - (**DEA**, CBP, ICE, State, NDIC)
Work with the U.S. Postal Service and private express mail delivery services to target illegal mail-order sales of chemical precursors, synthetic drugs, and pharmaceuticals, both domestically and internationally.

**Improve Intelligence Efforts Related to Synthetic Drugs** - (**NDIC**, DEA, CIA, CBP, ICE, State)
Intensify intelligence components' focus on gathering and sharing information regarding the nature and scope of synthetic drugs trafficking. Make full use of NDIC's real-time analytical database for both pre- and post-operation link analysis and document exploitation. Strengthen mechanisms for sharing actionable intelligence, trend analysis, and information on criminal organizations among the United States and concerned Western European countries.

**Target Raves Where Drug Use is Facilitated** - (**DEA**, DOJ)
Focus attention on the promoters and operators of rave events that facilitate the trafficking and abuse of MDMA and other club drugs, making innovative and effective use of the federal "crack house" statute, including amendments in the Rave Act.

**Consider New Legislation on Club Drugs** - (**DOJ**, DEA)
Federal officials should continue efforts to develop additional legislation to address legal issues that often arise with respect to club drugs and rave-type events. For example, the distribution of imitation controlled substances could be explicitly criminalized at the federal level, and the provisions governing controlled substance analogues and counterfeits could be clarified.

**Strengthen Controls on Internet Sales** - (**DOJ**, DEA)
Support legislation that regulates the burgeoning business of Internet sales of drugs, particularly controlled substances, by prohibiting the dispensing of controlled substances online without a valid prescription. The new law would define a valid prescription as one issued for a legitimate medical purpose in the usual course of professional practice, and would require at least one in-person medical evaluation by the prescribing doctor.

**Increase Internet Investigations** - (**DEA**, DOJ, NDIC, ICE, FDA, State)
Expand investigations and prosecutions of Internet-based synthetic and pharmaceutical drug diversion and sales, to include the establishment of task forces and coordination mechanisms dedicated to this purpose. Agencies should work with Internet Service Providers to assist them in limiting children's access to illegal drug sites.

**Target OxyContin and Vicodin Diversion** - (**DEA**, DOJ)
Support efforts to target individuals and organizations involved in the diversion, illegal sale, pharmacy theft, fraud, and abuse of OxyContin and other drug products containing oxycodone, hydrocodone, or hydromorphine, such as Vicodin and Lorcet.

**Seek Updated Sentencing Guidelines for Club Drugs** - (**DEA**, DOJ)
Work with the U.S. Sentencing Commission to review data on the impact and effectiveness of current sentences for trafficking in ketamine, GHB and its precursors and analogues, and other club drugs, and, if advisable, propose enhanced guidelines sentences.

**Share Law Enforcement Best Practices** - (**DEA**, DOJ)
Based on the successes achieved by local law enforcement in Southern California using reverse-buy investigations and by communities in the Midwest that have set more strenuous penalties and regulations regarding synthetic drugs, establish a mechanism for sharing best practices among federal, state, and local law enforcement as well as with international partners who are confronting synthetic drug threats.

# II. Nature of the Problem

## *A. Consumption Trends*

National indicators have shown a general increase over the last decade in the use of certain synthetic drugs, particularly among youth and young adults. However, recent data indicate that this trend may be changing for the better as part of broad reductions in teen drug use. Hospital statistics reflecting the adverse consequences of drug use as measured by the number of medical emergency mentions were statistically unchanged for all synthetic drugs except PCP from 2000 to 2002, yet long-term data reflect significant increases in emergencies involving a number of synthetic drugs.[4] Furthermore, in 2001 individuals age 25 and younger were involved in a disproportionate number of such emergencies involving MDMA, GHB, and LSD, and nearly three out of four emergency room episodes involving these three drugs also involved alcohol or another major substance of abuse.[5] More encouraging news is found in the 2003 Monitoring the Future (MTF) study, which reported a decline in the use of illicit drugs by teenagers, including the second consecutive year of major reductions in the use of MDMA, along with substantial decreases in the use of LSD.[6]

1. Methamphetamine

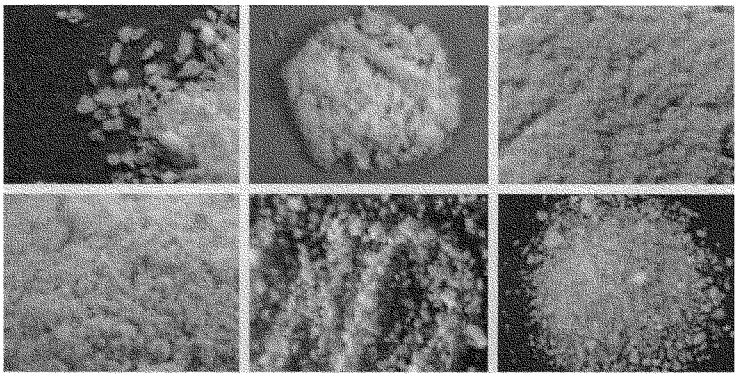
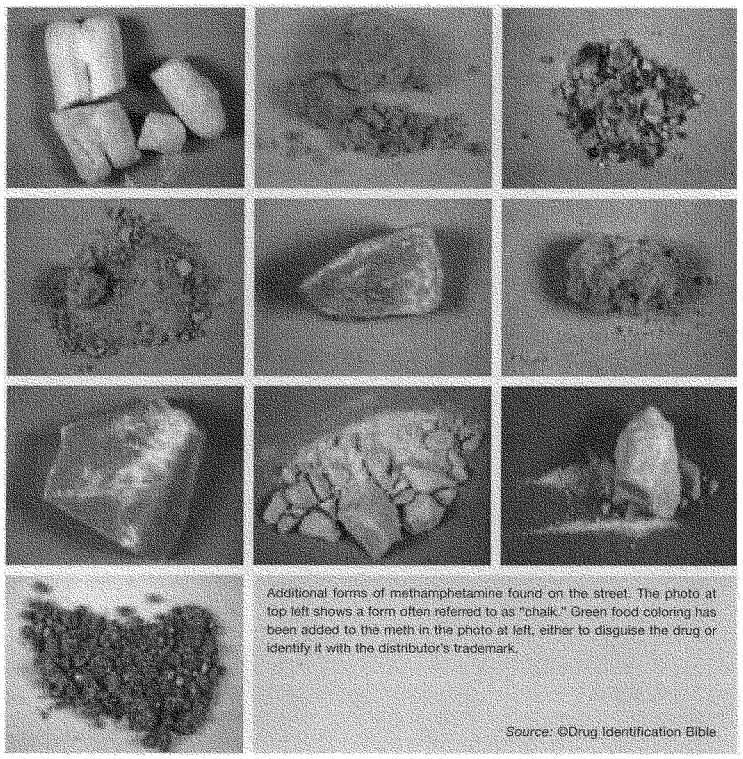


Figure 1: The appearance of methamphetamine varies with the production process. Scientific and chemical journals list more than 150 processes for methamphetamine production, along with an undetermined number of processes developed by clandestine chemists. Shown here are some of the most common forms of illicit methamphetamine.

*Source:* ©Drug Identification Bible



Additional forms of methamphetamine found on the street. The photo at top left shows a form often referred to as "chalk." Green food coloring has been added to the meth in the photo at left, either to disguise the drug or identify it with the distributor's trademark.

Source: ©Drug Identification Bible

The level of methamphetamine use in the United States has been rising among adults and declining among adolescents over the last several years. Over 12 million Americans have used methamphetamine in their lifetimes, according to the 2003 National Survey on Drug Use and Health, including an estimated 1.3 million past-year users. The mean age of the approximately 326,000 new methamphetamine users in 2001 was 18.7, and about 50 percent of the users were under the age of 18.

**PERCENTAGE REPORTING METHAMPHETAMINE USE**
***2003 NATIONAL SURVEY ON DRUG USE AND HEALTH***

| Age | Lifetime | Annual | Past 30 Days |
|---|---|---|---|
| **12–17** | 1.3% | 0.7% | 0.3% |
| **18–25** | 5.2 | 1.6 | 0.6 |
| **26+** | 5.7 | 0.4 | 0.2 |
| **12+ (Total)** | 5.2 | 0.6 | 0.3 |

*Figure 2: 2003 NSDUH Survey Results for Methamphetamine Use*

According to the 2003 Monitoring the Future study, there has been significant progress against methamphetamine use in the critical teenage segment of the population. The overall decline in use since questions regarding methamphetamine were first added to the study in 1999 is unmistakable—the rate of past-year methamphetamine use (also known as the "annual rate") dropped between 1999 and 2003 from 3.2 percent to 2.5 among 8th graders, from 4.6 percent to 3.3 percent among 10th graders, and from 4.7 percent to 3.2 percent among 12th graders.

| PERCENTAGE REPORTING METHAMPHETAMINE USE *2003 MONITORING THE FUTURE STUDY* | | | |
|---|---|---|---|
| **Grade** | **Lifetime** | **Annual** | **Past 30 Days** |
| **8th Grade** | 3.9% | 2.5% | 1.2% |
| **10th Grade** | 5.2 | 3.3 | 1.4 |
| **12th Grade** | 6.2 | 3.2 | 1.7 |

*Figure 3: 2003 Monitoring the Future Results for Methamphetamine Use*

The number of emergency room drug episodes involving methamphetamine increased from 13,505 in 2000 to 17,696 in 2002. Methamphetamine mentions occurred in approximately 3 percent of all emergency room drug episodes in 2002.[7] Previously, medical examiners participating in the 1999 Drug Abuse Warning Network (DAWN) survey mentioned methamphetamine in connection with 6 percent of all drug-related deaths and 8 percent of such deaths involving 18-25 year olds, and between 1994 and 1998 participating medical examiners associated a total of 2,601 deaths with methamphetamine use.

| EMERGENCY DEPARTMENT SYNTHETIC DRUG MENTIONS (DAWN) | | | | |
|---|---|---|---|---|
| **Year** | **Methamphetamine** | **MDMA** | **GHB** | **Ketamine** |
| **1994** | 17,537 | 253 | 56 | 19 |
| **1995** | 15,933 | 421 | 145 | ... |
| **1996** | 11,002 | 319 | 638 | 81 |
| **1997** | 17,154 | 637 | 762 | ... |
| **1998** | 11,486 | 1,143 | 1,282 | 209 |
| **1999** | 10,447 | 2,850 | 3,178 | 396 |
| **2000** | 13,505 | 4,511 | 4,969 | 263 |
| **2001** | 14,923 | 5,542 | 3,340 | 679 |
| **2002** | 17,696 | 4,026 | 3,330 | 260 |

*Figure 4: DAWN Synthetic Drug Mentions, 1994-2002*

Preliminary findings from urinalysis tests show high rates of recent methamphetamine use among adult arrestees in many urban areas in the West and Midwest in 2002. Positive test rates for methamphetamine use ranged between 20-31 percent for male arrestees and between 12-42 percent for female arrestees in Des Moines, Omaha, Phoenix, Portland, Salt Lake City, San Diego, and San Jose. In major cities in the eastern United States, positive test rates for adult arrestees were much lower.[8]

**ADULT ARRESTEES TESTING POSITIVE FOR METHAMPHETAMINE (%) (ADAM)**

| Primary City | 2000 | | 2001 | | 2002 | |
|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female |
| Des Moines, IA | 18.6 | 20.5 | 22.0 | 27.5 | 20.2 | 24.0 |
| Honolulu, HI | 35.9 | 47.2 | 37.4 | 36.1 | 44.8 | 50.0 |
| Omaha, NE | 11.0 | 13.2 | 15.6 | 10.3 | 21.0 | 12.0 |
| Phoenix, AZ | 19.1 | 24.1 | 25.3 | 32.3 | 31.2 | 41.7 |
| Portland, OR | 21.4 | 23.5 | 20.4 | 20.4 | 21.9 | 22.7 |
| Salt Lake City, UT | 17.1 | 28.9 | 17.2 | 18.8 | 21.9 | 37.7 |
| San Diego, CA | 26.3 | 28.7 | 27.9 | 37.4 | 31.7 | 36.8 |
| San Jose, CA | 21.5 | 40.0 | 30.2 | 38.2 | 29.9 | 42.8 |

*Figure 5: ADAM Testing Results for Methamphetamine, 2000-2002*

Although methamphetamine use is spreading eastward, it is still somewhat regionally concentrated in the West, Midwest, and parts of the South. In some states, such as Hawaii, local trends outstrip the wider regional and national norms. Methamphetamine currently stands out as the greatest drug threat to society in Hawaii. There are growing concerns in Hawaii regarding crystallized methamphetamine (called "ice") addiction rates in particular. Drug treatment facility admissions for methamphetamine use climbed by more than 300 percent in Hawaii from 1993 to 2000. Methamphetamine use also shows a high correspondence to the commission of crime in Hawaii; more than 44 percent of adult males and 50 percent of adult females arrested in Honolulu in 2002 tested positive for the drug. Moreover, there were 62 methamphetamine-related deaths in Honolulu in 2002, up from 27 in 1998.[9]

2. MDMA/Ecstasy

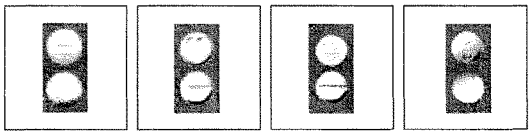


Figure 6: A close-up of the imprints on four MDMA tablets seized in 2001. Ecstasy manufacturers often stamp their products with familiar logos or other images designed to entice young people. *Source:* Wyoming Highway Patrol

MDMA use, which increased sharply between 1995 and 2000, is declining. The 2003 National Survey on Drug Use and Health estimated that 10.9 million individuals age 12 and over had tried MDMA during their lifetime. The Survey estimated that 1 million individuals tried MDMA for the first time in 2002, a significant decline from the 1.7 million new users in 2001 and 2000.

| PERCENTAGE REPORTING MDMA USE<br>*2003 NATIONAL SURVEY ON DRUG USE AND HEALTH* | | | |
|---|---|---|---|
| **Age** | **Lifetime** | **Annual** | **Past 30 Days** |
| **12–17** | 2.4 | 1.3 | 0.4 |
| **18–25** | 14.8 | 3.7 | 0.7 |
| **26+** | 3.1 | 0.3 | 0.1 |
| **12+ (Total)** | 4.6 | .9 | 0.2 |

*Figure 7: 2003 NSDUH Survey Results for MDMA Use*

MDMA use by high school students declined for the second year in a row, according to the 2003 Monitoring the Future study. The Monitoring the Future high school survey indicated increased annual MDMA use between 1999 and 2001: from 1.7 percent to 3.5 percent among 8th graders, from 4.4 percent to 6.2 percent among 10th graders, and from 5.6 percent to 9.2 percent among 12th graders. In contrast, annual MDMA use rates for high school students in 2003 were 2.1 percent among 8th graders, 3.0 percent among 10th graders, and 4.5 percent among 12th graders. These reductions were accompanied by significant declines in the rates of past-month MDMA use across all three grades in 2003 as well, and the lifetime use of MDMA dropped 32 percent, from 8.0 percent to 5.5 percent.

| PERCENTAGE REPORTING MDMA USE<br>*2003 MONITORING THE FUTURE STUDY* | | | |
|---|---|---|---|
| **Grade** | **Lifetime** | **Annual** | **Past 30 Days** |
| **8th Grade** | 3.2% | 2.1% | .7% |
| **10th Grade** | 5.4 | 3.0 | 1.1 |
| **12th Grade** | 8.3 | 4.5 | 1.3 |

*2003 Monitoring the Future Results for MDMA Use*

According to DAWN statistics, the number of emergency room drug episodes involving MDMA remained relatively stable between 2001 and 2002, with 5,542 mentions in 2001 and 4,026 mentions in 2002. However, the number of mentions in 2001 represents a 95 percent increase in the number of mentions since 1999 and almost a 22-fold increase over the estimated 253 MDMA mentions in 1994. Although less than one-third of all emergency room drug episodes in 2002 involved persons age 25 or younger, approximately 75 percent of emergency room MDMA episodes involved such individuals. The 2002 DAWN statistics also indicate that marijuana was mentioned in nearly 40 percent of emer-

gency department visits involving MDMA,[10] and the Community Epidemiology Work Group (CEWG) report from June 2002 noted that the annual number of deaths associated with MDMA may be increasing as well, although the mortality numbers remain low.[11]

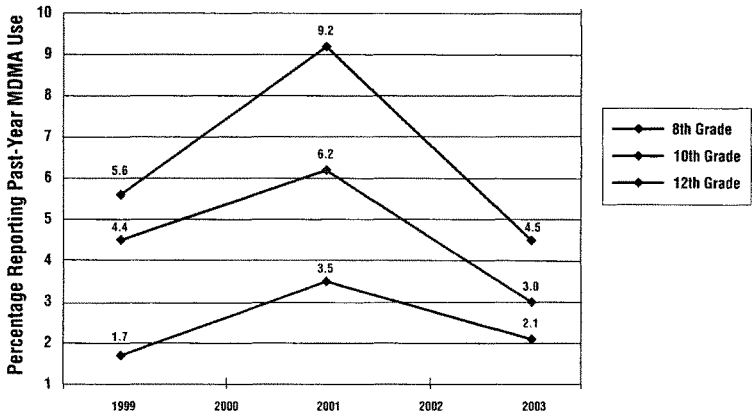



*Figure 8: 2003 Monitoring the Future Results and Trends for MDMA Use*

3. Other Club Drugs

GHB is the club drug which is most often associated with date rape. A capful can be slipped undetected into a beverage to incapacitate a victim. There were 3,330 GHB mentions in emergency room drug episodes in 2002, a figure that remained stable in comparison with the 3,340 GHB mentions in 2001. However the number of emergency room episodes associated with GHB in 2002 represents a one-third decrease from the 4,969 mentions in 2000. Like other club drugs, GHB is mostly used by young people, as reflected in DAWN statistics for 2002 showing that although less than one-third of all emergency room drug episodes that year involved individuals age 25 or younger, approximately 56 percent of emergency room GHB episodes involved such individuals.[12] Nonetheless, GHB use among high school students has shown little change since it was first measured in the Monitoring the Future survey in 2000. Annual prevalence rates in 2003 for students in grades 8, 10, and 12 are estimated at 0.9 percent, 1.4 percent, and 1.4 percent, respectively.[13]

The use of flunitrazepam (Rohypnol), which is associated with drug-facilitated sexual assault, appears to be on the decline. The Monitoring the Future survey estimates past-year Rohypnol use among 8th, 10th, and 12th graders in 2003 to be 0.5 percent, 0.6 percent, and 1.3 percent respectively. Rohypnol use among 8th, 10th, and 12th graders in 2002 was 0.3 percent, 0.7 percent, and 1.6 percent respectively.

Ketamine retains a small but persistent hold as a club drug used by young people. The Monitoring the Future study estimates the annual prevalence of ketamine use in 2003 for 8th, 10th, and 12th

graders at 1.1 percent, 1.9 percent, and 2.1 percent, respectively. There has been little change in these figures since 2000, when questions regarding ketamine use were first included in the survey. According to DAWN statistics, there were 260 ketamine mentions in emergency room drug episodes in 2002. Although less than one-third of all emergency room drug episodes in 2002 involved persons 25 and younger, approximately 68 percent of emergency room ketamine episodes involved such persons.[14]

Figure 9: **Rohypnol:** Although Rohypnol is illegal in the U.S., the drug is legally prescribed in some foreign countries. **GHB:** GHB is found in both powder and liquid form. **Ketamine:** Ketamine is available as a powder and in liquid injectible form. The drug is commonly stolen from veterinary clinics.

*Source:* DEA Museum

4. Other Synthetic Drugs and Diverted Pharmaceuticals

Non-medical use of addictive prescription drugs has been increasing throughout the United States at alarming rates. According to the National Survey on Drug Use and Health, in 2002, an estimated 6.2 million Americans reported past month use of prescription drugs for non-medical purposes. Nearly 14 percent of youth between the ages of 12 and 17 have used such drugs, which include pain relievers, sedatives/tranquilizers, or stimulants, for non-medical purposes at some point in their lives. Emergency room visits associated with narcotic pain relievers have increased 163 percent since 1995. The Administration already engages Federal, state, and local officials; the medical community; and businesses working in the area of Internet commerce to prevent and stop the illegal sale, diversion, and abuse of prescription pshychotherapeutic drugs. However, increased efforts are required in this area.

Oxycodone, particularly in the controlled release form of OxyContin, is a growing drug problem throughout the nation. Although the rate of non-medical use of oxycodone is still considered relatively low compared to major drugs of abuse on a national basis, there is evidence of an emerging problem in

many communities, particularly rural locales with limited public health and law enforcement resources. The estimated number of persons over age 12 who have illicitly used oxycodone rose from 221,000 to 399,000 between 1999 and 2000.[15] DAWN statistics for emergency room drug episodes involving prescription drugs containing oxycodone increased 22 percent from 18,409 mentions in 2001 to 22,397 mentions in 2002. This 2002 figure also represents a 107 percent increase over the 10,825 emergency room mentions in 2000 and a 450 percent increase over the roughly 4,000 mentions in 1994.[16] Monitoring the Future surveyed OxyContin use in 2003 and found annual prevalence rates for grades 8, 10, and 12 of 1.7 percent, 3.6 percent, and 4.5 percent, respectively.

The hallucinogen PCP continues to be used, often mixed with marijuana, and is reported at elevated levels in the emergency department data for certain cities in the DAWN network, including Chicago, Los Angeles, Philadelphia, and Washington, D.C. The Community Epidemiology Working Group has also found indications of increased PCP use in Phoenix and Texas as well. The estimated 7,648 PCP mentions in emergency room drug episodes in 2002 represent an increase of approximately 109 percent in the number of mentions since 1999.[17] Of the persons age 12 or over who first used PCP each year between 1994 and 1999 (estimated at 82,000 in 1994 and 151,000 in 1999), at least 60 percent were age 12-17. During that period the mean age of initiation dropped from 16.8 to 15.8 as well.[18] The 2003 Monitoring the Future study estimated an annual prevalence rate for PCP use among 12th graders of 1.3 percent.

Following a decline in use in the 1970s, LSD use was level in the late 1980s but began to increase between 1991 and 1996. Over the last two years, however, LSD use has fallen steeply to the lowest levels since Monitoring the Future data collection began.[19] For example, the annual prevalence rate for 12th graders, which peaked at 8.8 percent in 1996, was down to 1.9 percent in 2003; prevalence rates declined for 8th and 10th graders as well. Lifetime use of LSD fell 43 percent, from 6.6 percent to 3.7 percent. Moreover, the number of LSD mentions in emergency room drug episodes in 2002 dropped to 891 from 5,126 mentions in 1999. DAWN statistics indicate that although less than one-third of all emergency room drug episodes in 2002 involved persons age 25 or younger, approximately 76 percent of the emergency room LSD episodes involved such individuals.[20]

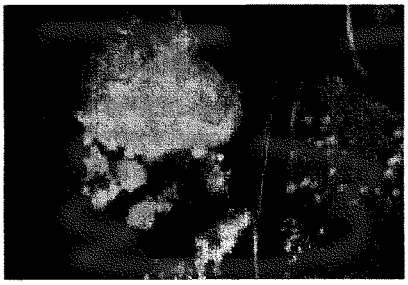


Figure 10: Pure PCP, as pictured here, is a white, odorless crystal with a metallic or bitter taste. Because of impurities resulting from makeshift manufacturing procedures, the color of much of the crystal PCP on the street will vary from tan to brown. *Source:* ©Drug Identification Bible

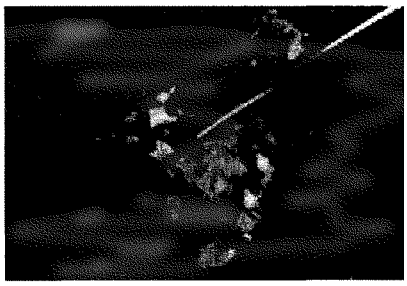


Figure 11: LSD crystals next to the point of a needle. When exposed to air, light, or heat, LSD will degrade and darken, eventually turning black. Purer forms of LSD are white or semi-clear in color. *Source:* ©Drug Identification Bible

## *B. Trafficking Trends*[21]

1. Methamphetamine

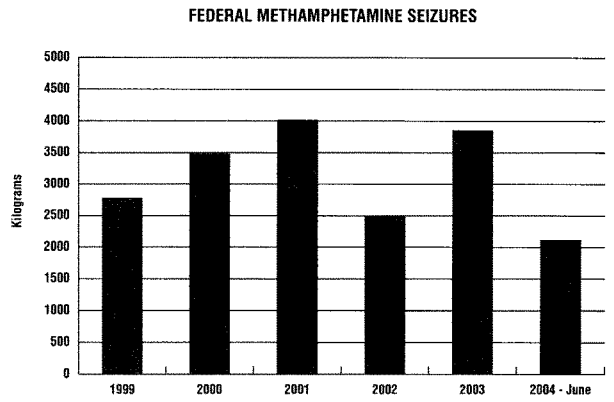



*Figure 12: Federal Methamphetamine Seizures*

Although both domestic and U.S.-Mexico border seizures have increased in three of the last four years and are a continuing concern, the surge in domestic lab seizures is particularly troubling (see Figure 13, next page). Methamphetamine accounts for about 96 percent of all clandestine drug laboratory seizures in the United States. The number of reports of domestic methamphetamine lab seizures continued to rise in 2003, with the Drug Enforcement Administration's (DEA) El Paso Intelligence Center (EPIC) receiving reports of more than 10,000 lab seizures, compared to the 9,193 seizures reported for 2002.[22] EPIC reported almost 5,000 labs seized in the first six months of 2004. The great majority of methamphetamine labs—over 95 percent in 2002—are seized and investigated by state and local law enforcement. California remains the state with the highest methamphetamine production levels. Hundreds of clandestine methamphetamine labs are seized in California each year.[23] Moreover, the large "super labs" in California, capable of producing more than ten pounds of methamphetamine per cycle, are responsible for the production of most of the methamphetamine trafficked illegally in the United States, despite a dramatic increase in the number of smaller, independent clandestine methamphetamine laboratories operating in the Midwest. Missouri leads the nation with over one thousand seizures of these smaller labs in 2003, and the number of labs seized in Arkansas, Oklahoma, and Tennessee tripled between 2000 and 2003.

The methamphetamine trade is controlled largely by well-organized Mexican crime groups that operate within a system of flexible alliances. Indeed, most of the large super labs in California are run by organizations with ties to Mexico. However, outlaw motorcycle gangs are gaining a larger share of domestic methamphetamine trafficking. Prices for methamphetamine vary greatly by locality, ranging between $20-$300 per gram across the 48 contiguous states.

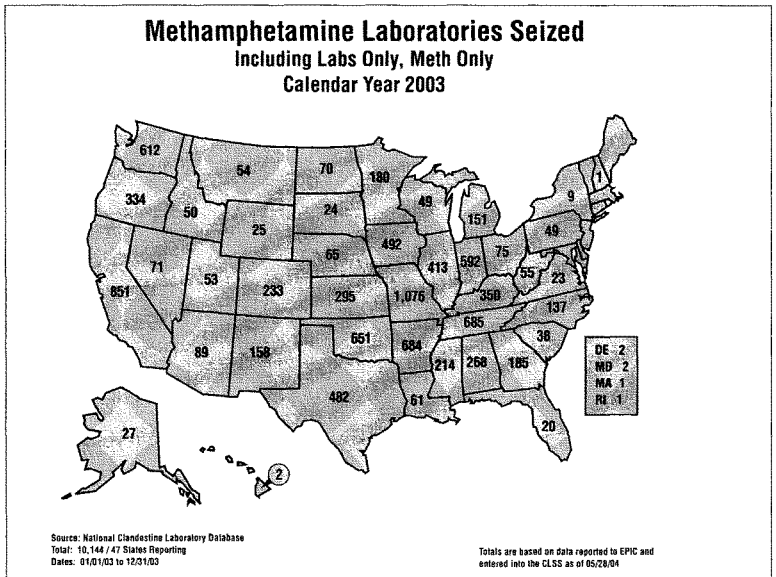



*Figure 13: Total of All Methamphetamine Laboratories Seized, 2003.*

High-purity, crystallized "ice" methamphetamine remains prevalent in Hawaii, but law enforcement has noted an increased market preference for ice methamphetamine on the U.S. mainland as well, and more is being produced to meet this demand. There are indications that ice methamphetamine may also be flowing into the United States directly from Asia and Mexico. In Honolulu, ice methamphetamine sells for $200-$400 per gram.

Figure 14: "Ice" is a purified form of methamphetamine that is ingested by smoking. Frequently described as resembling broken glass or shattered ice, the drug is essentially odorless and has a hard texture. Its purity is generally very high, often exceeding 90 percent.

*Source:* ©Drug Identification Bible

The trafficking of methamphetamine creates numerous hazards for the communities where it is produced. Officials estimate that for every pound of methamphetamine produced in a clandestine laboratory, approximately 5-6 pounds of toxic by-products are generally left over, with as much as ten pounds of toxic waste remaining in some cases.

Methamphetamine cooks bury the leftover chemical waste in the soil or dump it into septic systems or streams in rural areas, or into the plumbing when staying at hotels or rental homes. The toxic waste dumped into the soil or streams can then make

its way into the water table. Law enforcement officials discovered over 3,600 methamphetamine lab dumpsites in 2003 alone.24

The cleanup operation following the discovery of a dump or clandestine laboratory site is typically an extremely expensive endeavor. The initial cleanup of a site includes removing the chemicals and any leftover cooking equipment. These costs are typically covered by state, local, or federal government and average almost $2,700 per cleanup operation in California; DEA-funded cleanups average roughly $1,900 nationwide. Secondary cleanup entails removing contaminated soil and razing contaminated buildings, and funding the job is often left to the landowner. In some states liens are also placed on the property until the contamination is remediated. When combined with the opportunity cost of an affected property being legally condemned or deemed commercially or agriculturally unusable, the cost incurred by the property owner can run into the millions of dollars.

Figure 15: These five-gallon buckets from a meth lab contain a red-colored reaction liquid and "lye water," a strong alkali solution that will be added to the reaction liquid.

*Source:* Riverside County, CA, Sheriff's Department

The average cost of cleaning up a dump or lab site appears to be escalating as well. California authorities reported performing 2,088 initial cleanups of clandestine lab sites during 2000 at a cost of $4.3 million. While the number of clean-up sites in 2002 was smaller (1,846 sites), the total cost of performing the cleaning rose to $4.7 million. These shifts are explained by methamphetamine cooks' increasing sophistication, which enables the production of higher amounts of drugs at a single site. Some labs are now able to produce 100 pounds or more of methamphetamine per production cycle. This increased productivity leaves behind increased amounts of toxic waste, which can pollute the water supply and manifest itself in as-yet-unknown health and environmental consequences.[25]

Small, independent operators (sometimes called "mom and pop labs" or "small toxic labs") that produce ounce-size quantities of methamphetamine for local use and distribution account for the majority of the clandestine laboratory seizures in the United States. These labs initially emerged as a problem in the Midwest in the 1990s, using the relatively simple "Birch" method or the pseudoephedrine/iodine/red phosphorus methods of manufacturing methamphetamine. The proliferation of these small labs—which can be located in

Figure 16: Makeshift laboratory equipment and chemicals used in a small meth lab. Some of the more common chemicals found at meth labs include sodium hydroxide, methanol, acetone, isopropyl alcohol, ether (starting fluid), and charcoal lighting fluid.

*Source:* ©Drug Identification Bible

Figure 16a: A homemade punch used by a large-volume meth lab for removing over-the-counter tablets containing ephedrine or pseudoephedrine from blister packs.

*Source:* Riverside County, CA, Sheriff's Department

trailers, hotel rooms, or ordinary homes—has created many problems, including a dramatic increase in hazardous waste cleanups. The operational, financial, and manpower resources needed to combat the thousands of small clandestine drug labs in many parts of the country severely tax the resources of local police and sheriff's departments in smaller communities.

Thus, while the larger laboratories are of concern due to the amount of methamphetamine that can be produced and the concentration of toxic waste, the smaller toxic labs are of concern because they are so widespread. Furthermore, the potential for the public to be exposed to the toxic chemicals from these smaller laboratories is also much greater, since they are commonly found in either transient housing facilities or homes in residential neighborhoods. This fact also highlights what is probably the darkest side of the entire methamphetamine problem: drug-endangered children. In 2003, more than 3,000 children were found on site during law enforcement actions related to clandestine methamphetamine laboratories nationwide. Forty-one of these children were reported injured and one child was killed by explosions or fires at clandestine methamphetamine labs.[26]

| Year | Methamphetamine Lab Related Incidents | Children Affected |
|---|---|---|
| 2000 | 9,311 | 1,239 |
| 2001 | 13,839 | 2,345 |
| 2002 | 16,238 | 3,643 |
| 2003 | 16,506 | 3,625 |

*Figure 17: Children Affected in Methamphetamine Laboratory Related Incidents, 2000-2003*

2. MDMA/Ecstasy

Most of the MDMA consumed worldwide is produced in the Netherlands and, to a lesser extent, Belgium.[27] The United Nations Office on Drugs and Crime (UNODC) report *Ecstasy and Amphetamines: Global Survey 2003* states that 75 percent of responding countries indicated that the source of the MDMA seized in their country was the Netherlands. Belgium was the next most frequently mentioned country, appearing in the responses of 31 percent of the countries surveyed. Interpol reports that in 2001, 37 million MDMA tablets were seized worldwide. Of these, the Dutch reported that over 25 million, or approximately 68 percent, originated in the Netherlands. UNODC reports that total Ecstasy produced worldwide in 2002 was approximately 113 metric tons a year or 1.4 billion tablets. According to laboratory seizure data submitted to EPIC, there have never been more than 13 MDMA labs seized in the United States in a single year.[28]

Manufacturers in the Netherlands and Belgium have associated with organized crime syndicates from other European countries and Israel for distribution, with smugglers using methods such as express mail service, commercial air couriers, and air/sea freight.[29] Groups with ties to Southeast Asia

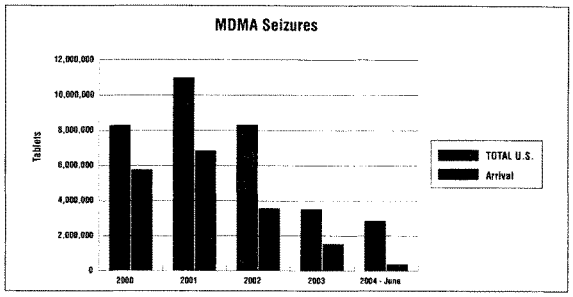



*Figure 18: Total U.S. & Arrival Zone MDMA Seizures, 2000-2004*

have also become heavily involved in the MDMA trade. Shipments to the United States typically contain 10,000 tablets or more, but, consistent with the patterns of declining use among young people, the total amount of MDMA entering the United States appears to be falling. As shown in Figure 18, annual aggregate seizures, both in the "arrival zone" (border area) and the rest of the country, have decreased in the past few years, reflecting the decline in usage.[30]

The ever-shifting routes used by MDMA traffickers require improved measures to monitor changes in the MDMA market. In 2000, 63 percent of MDMA tablets seized were smuggled into the United States by airline, 27 percent by express mail, and 10 percent by shipping. The departure points for these seized MDMA shipments were the Netherlands (77 percent), France (9 percent), Belgium (8 percent), Germany (3 percent), and Spain (3 percent).[31] In contrast, in 2003 26 percent of MDMA tablet were smuggled into the United States by airline, 19 percent by mail, 7 percent by express mail, 8 percent by shipping, and the remaining 40 percent by other means. The departure points for MDMA smuggled into the United States were the Netherlands (21 percent), Canada (18 percent), the United Kingdom (11 percent), France (6 percent), Germany (3 percent) and Belgium (2 percent).

Figure 19: Equipment for mixing glacial acetic acid, safrole, toluene, and other chemicals in a high-volume clandestine MDMA lab.

*Source:* Texas Department of Public Safety

The chemicals and equipment necessary to manufacture a kilogram of MDMA can cost as little as $500, but the process requires significantly more skill than the manufacture of methamphetamine.[32] It costs as little as 25 cents to produce a single MDMA pill that typically retails for $20-30, although prices vary widely. Retail prices per dosage unit in 2001 ranged from $10 to $60, and wholesale prices ranged from $5 to $17.

Quality and purity also vary, as MDMA is often cut with other substances such as caffeine, ephedrine, and dextromethorphan (DXM). Paramethoxymethamphetamine (PMA), a synthetic hallucinogen with potent stimulant effects, is also packaged and distributed as counterfeit or imitation MDMA. The DEA Source Determination Program's analysis of MDMA samples in 2000 revealed that 12 percent of the samples contained amphetamine or methamphetamine, but not MDMA; 5 percent contained no controlled substances; and 3 percent were determined to be other substances but were sold as ecstasy.[33]

According to DEA's System to Retrieve Information on Drug Evidence (STRIDE) data, Florida, New York, and California are the highest MDMA trafficking areas in the United States. Other states that have significant MDMA trafficking include New Jersey, Illinois, Georgia, Texas, Massachusetts, Virginia, and Washington, D.C.[34]

One region that appears to have a substantial connection to MDMA trafficking is Denver, Colorado. While most MDMA in Colorado comes from Europe (Belgium and the Netherlands), three MDMA labs were seized in Colorado in 2001.[35] Law enforcement officials have found that drug trafficking organizations are using Denver as a hub to reach several MDMA markets across the country, in cities such as Chicago, San Francisco, Detroit, and New York. The organizations involved have connections to the Middle East as well as Europe. In 2001, interagency task forces from the High Intensity Drug Trafficking Area (HIDTA) program took down an Israeli-run operation in the Denver region that was believed to be responsible for peddling more than 100,000 MDMA tablets each month.[36]

A dangerous new trend identified by the European Union's Police Organization, Europol, is the production of "super Ecstasy" pills with higher MDMA content than normal. These pills carry the normal logos and can be fatal to people used to normal doses. The extra heavy pills have been discovered in the Netherlands, Belgium, Denmark, and the United States.

3. Other Club Drugs

GHB is often manufactured clandestinely using recipes and ingredients obtained over the Internet. Most often the drug is consumed orally in liquid form (and rarely in powder, tablet, or capsule form). Individuals and organizations operating via the Internet commonly sell GHB analogues such as gamma butyrolactone (GBL) and 1,4-butanediol as "cleaning agents" in an attempt to mask their illicit activities. In 2001, a retail dose of GHB (by the capful, drops, etc.) sold for $5-$30.

Flunitrazepam (Rohypnol), which has never been approved for medical use in the United States, is smuggled from countries such as Mexico where it is legal and widely available. Reports of use, however, rapidly declined after 1996 legislation that increased penalties for trafficking in the substance.

Ketamine powder is not manufactured domestically, but is imported by U.S. firms from Germany—by far the largest source country—as well as from Colombia, China, and Belgium. U.S. firms process and package the powder into 10 mg/ml, 50 mg/ml, and 100 mg/ml injectable dosage forms. Ketamine reaches the illicit market by diversion from legitimate pharmaceutical sources or is obtained through burglaries of veterinary clinics (the most frequently reported source). Law enforcement officials have not encountered clandestinely manufactured ketamine, but ketamine smuggled from Mexico has been another significant source of supply to the illicit market.[37] However, thanks to coordinated law enforcement action in the United States and Mexico, key individuals within the ketamine-smuggling organization have been arrested, and the trafficking of ketamine from Mexico appears to be decreasing.

Licit ketamine is usually prepared in liquid formulations, and liquid is the primary form of illicit ketamine seized. Less frequently, street doses appear in crystal, powder, and, increasingly, tablet forms. Powder ketamine is obtained from pharmaceutical ketamine by evaporating off the liquid, and is snorted in 100 mg doses. A typical street package of ketamine powder (100 - 200 mg) sells for about $20. According to data collected from state and local forensic laboratories by the National Forensic Laboratory Information System (NFLIS), there were 2,126 cases associated with, and 1,387

drug items identified as, ketamine during 2002 (compared to 1,802 items in 2001 and 581 items in 2000). In 2002, this constituted roughly 12 percent of all club drug exhibits entered in the NFLIS database.

4. Other Synthetic Drugs and Diverted Pharmaceuticals

The illegal diversion, theft, and medical mismanagement of prescription drugs (particularly opioid pain medications) have increased and, in some areas, present a larger public health and law enforcement challenge than cocaine or heroin. According to the most recent National Survey of Drug Use and Health, the misuse of psychotherapeutic drugs—pain relievers, tranquilizers, stimulants, and sedatives—was the second leading category of illicit drug use in 2002, following marijuana. An estimated 6.2 million Americans (approximately 2.6 percent of the population age 12 and older) had used a psychotherapeutic drug for nonmedical reasons in the month prior to the survey. The bulk of this abuse involves narcotic analgesics—an estimated 4.4 million Americans are past-month (so-called current) nonmedical users of pain relievers.

Reports of the diversion and abuse of oxycodone in the brand pharmaceutical OxyContin have spread from the rural areas of the East to all regions of the United States, based on recent emergency room and law enforcement data. Common means of obtaining oxycodone include unscrupulous physicians and pharmacists, "doctor-shopping," and fraudulent and altered prescriptions. The number of pharmacies that have been robbed by criminals seeking OxyContin has increased dramatically as well.

Illicit PCP is primarily manufactured clandestinely in Southern California, with limited clandestine production occurring in Indiana and, more recently, in Maryland. Most of the PCP produced in Southern California is destined for distribution to other U.S. locations, primarily along the East Coast. New York is one of the largest mid-level distribution hubs for PCP. The availability of PCP appears to be sporadic, with high levels of availability recently in Philadelphia, Chicago, New York, Los Angeles, Texas, and Washington, D.C. Packaging, purity, and pricing vary greatly; PCP is typically sold for use in combination with marijuana, alcohol, and other licit and illicit products. According to data collected by DEA near the end of 2002, PCP-laced cigarettes sell for about $5-30 apiece; powder and liquid forms sell for about $20-30 per gram, and liquid ounces sell for $125-1,000. Wholesale prices for one gallon of liquid PCP are $6,500-8,000 in Los Angeles and $12,000-20,000 in New York.

Historically, LSD has been manufactured by a small number of chemists operating clandestine laboratories in California, but a very large lab was discovered and seized recently in the Midwest. LSD is available in almost every state, and the cost of a single dose, commonly referred to as a "hit," typically ranges from $1 to $10.

5. Internet Sales of Pharmaceuticals

In recent years, pharmacy websites have proliferated on the Internet; offering both controlled and non-controlled substances. While inappropriate online sales and misuse of non-controlled substances raise significant concerns, this Action Plan focuses on the sale and abuse of products containing controlled substances, notably the highly addictive narcotics hydrocodone (including Vicodin, on Schedule III) and Oxycodone (including OxyContin, on Schedule II). Obtaining controlled substances online is convenient—too convenient: The majority of online pharmacies offer to dispense drugs without valid prescriptions, making the Internet a haven for illicit drug-seekers.

Figure 20: A small glass vial containing about 3 cc's of liquid PCP. Smoking a cigarette that has been dipped in liquid PCP is the most common way of ingesting the drug.

*Source:* ©Drug Identification Bible

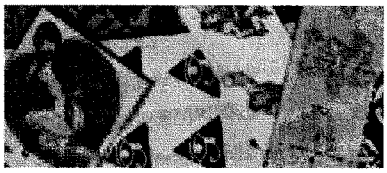


Figure 21: Most LSD seen on the street is in the form of blotter paper. The sheets of absorbent blotter paper are perforated into small squares and dipped into LSD that has been dissolved and diluted in alcohol. The blotter paper is often stamped with the distributor's trademark design.

*Source:* ©Drug Identification Bible

LSD being ingested via blotter paper on the tongue. Although the drug is almost always taken by means of oral absorption, it can also be injected, absorbed through the skin, or swallowed.

*Source:* ©Drug Identification Bible

Many sites substitute a simple online questionnaire for a face-to-face examination and patient supervision by a health care practitioner.

In a study released in early 2004, the National Center on Addiction and Substance Abuse (CASA) documented the explosion of illegal distribution of prescription drugs over the Internet. The exact number of online pharmacies is difficult to ascertain. Of 495 websites offering prescription drugs identified by the CASA study, only one-third were "anchor" sites, where customers actually purchase the drugs; the rest were "portal" sites that direct customers to anchor sites. The report found that 73% of drugs offered on these websites were Schedule II and III controlled substances. Regardless of the number of such websites, their predominant characteristic is that very few—6% in the CASA study—require customers to have a prescription in order to purchase drugs. The sites have no mechanism to prevent children from purchasing prescription drugs. About half of the sites offer only an online "consultation," an inadequate substitute which the American Medical Association has found not to meet appropriate standards of medical care.

# III. Response to the Problem

## *A. Prevention*

1. Current Efforts

Demand reduction is a critical component of any sound drug strategy. To be effective, drug prevention programs generally should be long-term and comprehensive, with the goal of preventing any illicit drug use, not just the abuse of one drug or class of drugs. Nevertheless, as evidenced by the increasing illegal use of certain licitly manufactured and compounds manufactured in clandestine laboratories, demand patterns can change quickly, often with significant risk to public health and safety. Effective prevention therefore also must include early warnings about such emerging drug threats and quick community response through education and outreach efforts.[38]

Scientific research supports targeted short-term prevention efforts and more general long-term prevention efforts by identifying specific drugs subject to abuse and related demographic trends. These trends include patterns of drug use initiation and progression, motivation and risk factors associated with drug use, and factors that protect against drug use. Prevention programs should be based on this research, beginning with the scientific collaboration needed to identify and develop testing methods and products for specific synthetic drugs, and should address specific community needs, in some cases focusing efforts on one or more particular drugs. Furthermore, prevention programs should seek the voluntary participation of many community components—individuals, families, schools, religious institutions, businesses, law enforcement, social service agencies, the media, and other organizations—in a coordinated manner according to community needs and available resources.

In response to the rise in the use of synthetic drugs and diverted pharmaceuticals, more focused data-gathering and prevention programs are beginning to emerge. The Department of Health and Human Services' National Institute on Drug Abuse (NIDA)—which funds 85 percent of the world's research on drug use and addiction—has been a leader in this regard. Its Community Epidemiology Work Group (CEWG) provides ongoing monitoring of emerging trends in drug use, including the most up-to-date information on synthetic drugs and diverted pharmaceuticals. NIDA has also hosted conferences focused on important prevention issues concerning MDMA/Ecstasy and GHB. Moreover, NIDA has partnered with several national non-governmental organizations in an education, prevention, and research effort regarding the use of methamphetamine, MDMA, GHB, LSD, and Rohypnol. This partnership funds research on these drugs as well as a multi-media public education campaign that includes: the dissemination of a *Community Drug Alert Bulletin* on "Club Drugs" to approximately 500,000 health care and treatment providers; the distribution of a *Research Report on Methamphetamine Abuse and Addiction*; and the development of teaching aids for use in elementary and high school classrooms.[39]

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services has also increased its focus on preventing the consumption of synthetic drugs and diverted pharmaceuticals. SAMHSA has undertaken a research-based initiative to target high-risk groups with prevention messages regarding club drugs, and its Center for Substance

Abuse Prevention (CSAP) maintains an Internet site dedicated to model prevention programs targeting youth. CSAP further facilitates the dissemination of pertinent information on substance abuse prevention research through its National Clearinghouse, which is also available on-line. Under the Community-Initiated Prevention Interventions program, SAMHSA has funded 27 grants that will address the use of MDMA, other club drugs, methamphetamine, and inhalants, either through the development of prevention intervention models or prevention infrastructure programs.[40]

In addition, SAMHSA oversees the day-to-day operation of the comprehensive Drug-Free Federal Workplace program and the National Laboratory Certification Program (NLCP). The NLCP provides for the development, validation, dissemination, and ongoing quality assurance of workplace forensic drug testing methods. The use of specific drug tests in NLCP-certified laboratories is required for all federal agencies, the industries regulated by the Department of Transportation, the Nuclear Regulatory Commission, private industry, and, increasingly, the Department of Homeland Security. Under existing regulations, tests are specifically required to be capable of detecting methamphetamine use. New federal regulations that are nearing completion will mandate testing for MDMA, and tests for other drugs, including a number of high abuse-potential synthetic drugs, are being considered as well. The Department of Health and Human Services is also focusing on methamphetamine through its Targeted Capacity Expansion Grant program, which has a general mission to identify and respond to emerging drug problems, and is promoting programs that target drug use in families and in the workplace.[41]

The Office of Safe and Drug-Free Schools (SDFS) in the Department of Education is the primary vehicle of the federal government for reducing drug, alcohol, and tobacco use and violence in schools. The SDFS administers, coordinates, and recommends policy for improving the quality of programs and activities that are designed to provide financial assistance for drug and violence prevention and to promote the health and well being of students in elementary and secondary schools and institutions of higher education. Activities may be carried out by state and local educational agencies and by other public and private nonprofit organizations. The office also: participates in the formulation and development of Administration policies related to violence and drug prevention; coordinates with other federal agencies on issues related to comprehensive school health; and participates with other federal agencies in the development of a national research agenda for drug and violence prevention.

The Office of National Drug Control Policy (ONDCP) promotes effective prevention activities through ONDCP-directed programs such as the National Youth Anti-Drug Media Campaign and through federal government coordination efforts, such as the Interagency Demand Reduction Group. In August 2000, the Media Campaign began a nationwide radio and Internet initiative designed to educate people about the dangers of MDMA and address faulty perceptions that the drug is harmless.[42] More recently, the Media Campaign ran an extensive, $40 million ad campaign calling attention to the dangers of Ecstasy.

DEA is also heavily involved in programs to prevent the use of synthetic drugs and diverted pharmaceuticals. Thirty-three full-time special agents are dedicated to work on demand reduction programs throughout DEA field divisions. Since an August 2000 international conference on club drugs, DEA has co-sponsored regional conferences along with community coalitions and local law enforcement in almost all DEA field divisions to disseminate general and scientific information on club drugs to law enforcement personnel, medical and treatment professionals, teachers, parents, and community organizations.[43] In addition, DEA's "Operation X-Out" adds a strong public awareness

component to its enforcement facets through "town hall" meetings featuring discussions between local residents and panels of local and national experts. DEA also provides several informative pamphlets regarding synthetic drugs and diverted pharmaceuticals, including *Ecstasy and Predatory Drugs and Tips for Parents: The Truth About Club Drugs.*[44]

2. Recommendations

**Develop an Early Warning and Response System:** - (**NDIC**, DOJ, HHS, ONDCP)
Establish a comprehensive, interagency, early warning and response system to detect the emergence of new drugs and trends. Appendix A lays out the possible parameters of such a system in detail, but it should include increased research efforts to develop and disseminate accurate, reliable, and cost-effective tests for identifying new synthetic drug use trends.[45] Particular focus should be given to earlier identification and routine detection of licitly produced drugs with high illicit use potential.[46]

**Enhance Public Outreach Efforts Focusing on Synthetic Drugs:** - (**SAMHSA,** DOJ, ONDCP)
Develop a multimedia education campaign on the consumption of synthetic drugs, focusing initially on methamphetamine. The program should, as appropriate, incorporate messages about the environmental threat and risks to children from clandestine labs. Ensure adequate dissemination of all pertinent materials and information on synthetic drugs through the Department of Education's Office of Safe and Drug-Free Schools.

**Improve Education and Training on Pharmaceuticals:** - (**DEA,** FDA, SAMHSA, ONDCP)
Ensure product labeling that clearly articulates conditions for the safe and effective use of controlled substances, including full disclosure of safety issues associated with pharmaceuticals. Develop a mechanism for the wider dissemination and completion of approved Continuing Medical Education courses for physicians who prescribe controlled substances. Develop Internet public service announcements regarding the potential dangers and illegality of online direct purchases of controlled substances.

**Develop Best Practices to Assist Drug-Endangered Children:** - (**HHS,** EPA, DOJ, DEA, ONDCP)
Develop protocols for assisting drug-endangered children that generally address staff training; roles and responsibilities of intervening agencies; appropriate reporting, cross reporting, information sharing, and confidentiality; safety procedures for children, families, and responding personnel; interviewing procedures; evidence collection and preservation procedures; medical care procedures; and community resource development.

**Research and Develop Targeted Prevention Programs:** - (**NIDA,** ONDCP)
Support research on the initiation of methamphetamine use and the progression of use leading to addiction. Programs should be developed to target high-risk groups or communities and to increase community involvement in prevention efforts.

**Improve Data on Afflicted Geographic Areas:** - (**NDIC,** SAMHSA, DOJ, ONDCP)
Build on existing Geographical Information System (GIS) resources and databases to integrate federally mandated drug test results, crime laboratory evidence analysis, population demographics, and other meaningful data pertaining to synthetic drugs and diverted pharmaceuticals in a manner that supports geographically based prevention and intervention efforts.[47]

**Examine the Use of Prescription Narcotics:** - (**NIDA,** SAMHSA, FDA, NIJ, DEA)
Assess the scope and magnitude of the licit and illicit use of prescription narcotic analgesics, in particular OxyContin, including the pursuit of additional data sources in cooperation with the Food and Drug Administration (FDA), the National Institute for Justice (NIJ), private entities, and others.

## *B. Treatment*

1. Current Efforts

While prevention programs are important for ensuring that individuals do not fall victim to the lure of illegal drugs, treatment initiatives are critical for providing those who do develop a dependency with an opportunity to reclaim control of their lives. Treatment is therefore a key component of our national efforts to eliminate the scourge of illegal drugs from society. The research-based efforts of NIDA and SAMHSA form the foundation for all future progress in the treatment of synthetic and diverted pharmaceutical drug dependencies.

In addition to the major role it plays in prevention-based research, NIDA is also a leader in studies of the pharmacology and toxicity of methamphetamine, MDMA, and other synthetic drugs, and in developing treatments for their abuse. For example, in 2002, NIDA launched a Methamphetamine Clinical Program to implement recommendations of the Methamphetamine Addiction Treatment Think Tank. NIDA has also established clinical treatment trials and studies involving behavioral therapies and medication alternatives for methamphetamine-dependent patients in several cities plagued by the methamphetamine epidemic (including Des Moines, Kansas City, San Antonio, Los Angeles, San Diego, and Honolulu). Following up on conferences dedicated to GHB and MDMA in 2000 and 2001 respectively, NIDA is now assessing needs and strategies with respect to MDMA and GHB abuse treatment through venues such as a "club drug" working group, a panel of experts from across the Institute. Moreover, as a result of the many insights that have been developed through the research that it supports related to treatments for drug addictions, NIDA has produced several helpful pamphlets, including *Principles of Drug Addiction Treatment: A Research-Based Guide,* which outlines the essential components of effective treatment programs.

SAMHSA has also been actively involved in efforts aimed at the treatment of synthetic and diverted pharmaceutical drug use. SAMHSA maintains treatment-related online tools for finding a qualified treatment center (the Substance Abuse Treatment Facility Locator), exchanging information with concerned State agencies (the Treatment Improvement Exchange), and accessing the National Clearinghouse for Alcohol and Drug Information.[18] SAMHSA's Center for Substance Abuse Treatment (CSAT) coordinates several programs that help communities establish effective treatment services for emerging drug epidemics, and has recently targeted the expansion of methamphetamine treatment in certain geographical areas. CSAT has released a book titled *Treatment for Stimulant Abuse* as well, which outlines a comprehensive series of best practices guidelines, including treatment approaches with documented success, practical applications, and explanations of treatment issues for special groups and settings.

Additionally, CSAT administers the Programs of Regional and National Significance, which provide funding to increase the availability and study the efficacy of treatment programs for synthetic and other drugs, and to disseminate information learned from research on treatments of substance dependencies. In particular, the Programs have allocated resources for determining the effectiveness of available methamphetamine addiction treatments and the cost-effectiveness of the various treat-

ment approaches. For example, CSAT has awarded grants for testing, and a contract for conducting follow-up studies on, a 16-week treatment plan for methamphetamine use developed by UCLA's Integrated Substance Abuse Programs (ISAP)/Matrix Institute. During this vanguard three-year study, the grants supported training of treatment and research staff, as well as development of additional clinical capacity supporting approximately 1,000 clients at eight sites. Follow-on research continues.

2. Recommendations

**Increase Treatment Capacity:** - (**HHS**)
Assess treatment needs for synthetic and diverted pharmaceutical drug addiction and, if necessary, expand that capacity in the community and in correctional facilities. Particular emphasis should be given to the development of additional treatment capacity for methamphetamine users, to include follow-up services that address the protracted recovery period associated with methamphetamine dependency.

**Research Treatment for Synthetic Drug Abuse:** - (**HHS,** NIDA, SAMHSA, ONDCP)
Increase research on the physical and psychological effects of methamphetamine and other synthetic drugs, as well as on the development of effective treatment protocols for synthetic drugs.

**Develop Guidelines for Juvenile Drug Treatment:** - (**NIDA,** SAMHSA)
Fund research on, and pursue the development of, guidelines with respect to the treatment of juveniles, who often are not adequately served in existing drug treatment programs designed for adults.

**Develop Early Response Treatment Protocols:** - (**NIDA,** SAMHSA)
Develop and disseminate early response protocols addressing requests for treatment of dependency on emerging synthetic drugs and diverted pharmaceuticals.

**Study Options for Criminal Justice System Treatment:** - (**NIDA,** SAMHSA, NIJ)
Invest in additional studies on the efficacy of various comprehensive treatment programs for synthetic drug abuse and on their adaptability to diverse individual and community needs, especially those unique to the criminal justice system.

**Expand Dissemination of Treatment Best Practices:** - (**NIDA,** SAMHSA, ONDCP, DEA)
Expand capabilities to disseminate pertinent research results and best practices training techniques as part of the overall effort to increase access to effective treatments for dependencies on synthetic and diverted pharmaceutical drugs.

## *C. Regulation of Chemicals and Drugs*

1. Current Efforts

### a. Introduction

Regulatory measures to control key precursor and essential chemicals are critical to preventing the production of the clandestinely synthesized drugs discussed in this Action Plan. Effective chemical control has increased the difficulty, risk, and cost of methamphetamine production. In the United States, DEA has the lead role in this endeavor. However, two organizations within the Department of

Homeland Security—the Bureau of Immigration and Customs Enforcement (ICE) and the Bureau of Customs and Border Protection (CBP)—perform integral functions on the import/export side of the chemical control system. As the agencies supervising U.S. ports-of-entry, these organizations monitor commercial imports and exports of chemicals to ensure compliance with DEA registration and permit requirements.

**CHEMICALS USED IN METHAMPHETAMINE PRODUCTION**

| CHEMICAL | HAZARDS |
|---|---|
| **Pseudoephedrine** | Ingestion of doses greater than 240 mg. causes hypertension, arrhythmia, anxiety, dizziness, and vomiting. Ingestion of doses greater than 600 mg. can lead to renal failure and seizures. |
| **Acetone/Ethyl Alcohol** | Extremely flammable, posing a fire risk in and around the laboratory. Inhalation/ingestion causes severe gastric irritation, narcosis, or coma. |
| **Freon** | Inhalation can cause sudden cardiac death or severe lung damage. Corrosive if ingested. |
| **Anhydrous Ammonia** | Inhalation causes edema of the respiratory tract and asphyxia. Contact with vapors damages eyes and mucous membranes. |
| **Red Phosphorus** | May explode on contact or friction. Ignites if heated above 260°F. Vapor from ignited phosphorus severely irritates the nose, throat, lungs, and eyes. |
| **Hypophosphorus Acid** | Extremely dangerous substitute for Red Phosphorus. If overheated, deadly phosphine gas is released. Poses a serious fire and explosion hazard. |
| **Lithium Metal** | Extremely caustic to all body tissues. Reacts violently with water and poses a fire or explosion hazard. |
| **Hydriodic Acid** | A corrosive acid with vapors that are irritating to the respiratory system, eyes, and skin. If ingested, causes severe internal irritation and damage that may cause death. |
| **Iodine Crystals** | Gives off vapor that is irritating to respiratory system and eyes. Solid form irritates the eyes and may burn skin. If ingested, it will cause severe internal damage. |
| **Phenylpropanolamine** | Ingestion of greater than 75 mg. causes hypertension, arrhythmia, anxiety, and dizziness. Quantities greater than 300 mg. can lead to renal failure, seizures, stroke, and death. |

*Source: US Department of Justice, Information Bulletin: Children at Risk (7/2002)*

Since the chemical industry is highly international, multilateral cooperation in chemical control is critical. The United States is currently involved in several multilateral initiatives to track chemicals used in the manufacture of amphetamine, methamphetamine, amphetamine-type stimulants such as MDMA, and other synthetics, with the goal of involving China, India, the Netherlands, Canada, Mexico, Eastern European nations such as Poland and the Czech Republic, and other countries in cooperative chemical control efforts. The legal framework for international chemical control is provided by Article 12 of the 1988 United Nations (UN) Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. This Convention establishes obligations and international stan-

dards for member nations to control domestic and international chemical commerce and prevent the diversion of 23 specified chemicals. Parties to the Convention pledge to cooperate with one another toward this objective. Other international vehicles that have promoted chemical control include:

- The June 1998 United Nations General Assembly Special Session (UNGASS), at which two of the five action plans adopted addressed precursors generally and amphetamine-type stimulants and their precursors in particular.
- The May 1997 United States/European Union (EU) Chemical Control Agreement, which included a commitment to consult and inform participating nations on shipments of controlled chemical substances in order to prevent their diversion from legitimate to illicit purposes; a Follow-Up Working Group continues to solidify U.S.-EU cooperation in chemical control.
- The annual meetings of the UN Commission on Narcotic Drugs (CND), which highlight emerging chemical control concerns.

### b. U.S. Chemical Controls

The linchpin of U.S. efforts to curtail international chemical diversion is a 15-day advance notification requirement that enables DEA to verify the legitimacy of a proposed shipment and suspend suspicious transactions.[50] In 1995, DEA initiated a "letter of non-objection" (LONO) process for imports of ephedrine and pseudoephedrine from China, the Czech Republic, and India. This system facilitates international cooperation under the 1988 UN Convention and meets the needs of governments in chemical exporting countries to ensure that chemical exports are for legitimate purposes.[51]

The history of chemical regulation and related enforcement provisions in the United States has followed a continuing cycle of government action and trafficker reaction. Each new regulatory measure gives rise to one or more counter-measures by traffickers, but the system of laws and regulations has, on the whole, made it more difficult and costly for traffickers to procure the chemicals they need. Following is a summary of major legislation:

- Comprehensive chemical control began in earnest in the United States with the Chemical Diversion and Trafficking Act of 1988, which established the basic scheme of chemical regulation in place today for 20 chemicals, including twelve "precursors" and eight "essential chemicals."[52]
- The Crime Control Act of 1990 added twelve chemicals to the list of precursors.[53]
- The Domestic Chemical Diversion and Control Act of 1993 brought over-the-counter ephedrine products under regulatory control, required registration of handlers of "List I" chemicals (most of which were formerly termed "precursors"), and increased DEA's flexibility in applying the 15-day advance notice requirements for exports and imports of specified listed chemicals to specified countries.[54]
- The Comprehensive Methamphetamine Control Act of 1996 (MCA): (1) narrowed the exemption for sales of certain drug products containing methamphetamine and amphetamine precursor chemicals by regulating retail sales of 24 grams or more, although it created a "blister pack" exemption to that rule; (2) required monthly reporting by "mail order" firms that sell

methamphetamine and amphetamine precursor chemicals; and (3) added iodine and hydrochloric gas to the list of regulated chemicals.[55]

- The newest legislation targeting the illicit manufacture and distribution of methamphetamine is the Methamphetamine Anti-Proliferation Act (MAPA), signed into law on October 17, 2000. MAPA retained the blister pack exemption established by the Comprehensive Methamphetamine Control Act of 1996. However, it amended that Act by reducing the retail sale recordkeeping and reporting threshold quantity of non-exempt pseudoephedrine and phenylpropanolamine products to nine grams in a single transaction with a maximum three-gram package size.

An increasingly critical layer of chemical control occurs at the state level. Some states that have felt the brunt of the clandestine laboratory problem - notably in the West and Midwest - have imposed restrictions on chemical sales that supplement federal law. Appendix F includes a short description of the recent amendments in the Oklahoma and Missouri state chemical control laws. In Oklahoma, products containing pseudoephedrine may be sold only by a licensed pharmacist or pharmacy technician, and purchasers must sign a log book and present identification. This law, enacted in April 2004, already appears to have led to a sharp reduction in lab activity in that state. Aggressive chemical control schemes of this type are examples of states performing a function honored by Supreme Court decisions over the years, to serve "their role as laboratories for experimentation to devise various solutions where the best solution is far from clear."[56] States may well lead the next wave of innovation in the area of chemical control, implementing approaches that could serve as models for other states and even for the Federal Government.

The federal legal/regulatory system remains dynamic. As DEA continues to tighten the system, the list of chemicals subject to control has expanded. In addition to the items listed in the summary above, regulations effective November 16, 2001 made red phosphorous, white phosphorous, and hypophosphorous acid List I chemicals.[57] In consultation with the Department of Justice, DEA promulgated new "chemical mixture" regulations to clarify which characteristics and concentrations of dietary and nutritional supplements—many of which contain ephedrine and pseudoephedrine—will fall under the chemical regulatory scheme.[58]

However, the regulatory system is meaningful only insofar as it is enforced. DEA has increased its scrutiny of businesses' applications for registration to distribute, manufacture, import, or export List I chemicals. Pre-registration screening is more rigorous than ever. For example, between 2003 and early June 2004, 43 firms surrendered their registrations, three registrations were revoked, 19 were denied, and 358 applications were withdrawn. DEA has also intensified its administrative litigation against registrants and applicants. From January 2003 through June 2004, DEA issued 38 "orders to show cause" why registrations for List I chemicals should not be revoked or why pending applications should not be denied. Of those 38 orders, three involved immediate suspension based on a threat to public health and safety. The number of chemical investigations initiated by DEA since FY 1999 has climbed from 133 cases in FY 1999 to 528 cases in FY 2003.

DEA has increased scrutiny of methamphetamine-related chemical imports in particular. The tables below show the amounts of raw material and the number of tablets of bulk pseudoephedrine and ephedrine that were imported into the United States during calendar year 2003 and January-March 2004, and how much of it has been withdrawn. The low number of shipments withdrawn is significant and may be attributed to several factors: (1) closer scrutiny of potential imports;

(2) decline in the affected chemical registrant population due to criminal and civil actions against rogue companies; and/or (3) successful use of the "order to show cause" process as a control mechanism. DEA's ability to vigorously investigate potential shipments for possible downstream diversion prior to import into the U.S. has forced importers either to comply with federal regulations or reduce the amounts of their imports. Often, importers will withdraw their request for an import when concerns about downstream diversion are expressed by DEA, opting to avoid a possible DEA administrative proceeding to suspend a suspicious shipment.

| | Raw & Tablet Pseudoephedrine Imports | | | Raw & Tablet Ephedrine Imports | | |
|---|---|---|---|---|---|---|
| Year | Total Permitted (kilograms) | Total Stopped (kilograms) | Percent Withdrawn | Total Permitted (kilograms) | Total Stopped (kilograms) | Percent Withdrawn |
| 2003 | 707,528.3 | 900 | <1% | 208,815.6 | 4,297 | <1% |
| 2004 (March) | 265,033.8 | 4,000 | <1% | 79,492.27 | 500 | <1% |

*Figure 22: Raw and tablet Pseudoephedrine and Ephedrine Imports, Calendar Year 2003 – March 2004*[59]

An important component of chemical control is law enforcement's partnership with the retail and pharmaceutical industries.[60] DEA officials in the Office of Diversion Control met in September 2002 with representatives of distributors and wholesalers of listed chemical products and in February 2003 with representatives of retailers. A national chemical industry conference was held in boston in 2004. Outside of these meetings, some companies have taken significant steps on their own. Some retail chains have voluntarily decided to limit the sales volumes of pseudoephedrine pills at levels below those required by state and federal law. Additionally, some pharmaceutical companies are attempting to develop new technologies that would hinder methamphetamine traffickers' ability to use the pseudoephedrine in licit pharmaceutical products for illicit purposes.[61]

### c. The International Challenge

The smuggling of pseudoephedrine products into the United States from Canada and other nations poses a major regulatory, law enforcement, and diplomatic challenge. Since most raw (or bulk) pseudoephedrine is not produced in the Americas (with the exception of two U.S. firms that convert imported ephedrine into pseudoephedrine), Canadian firms, like most U.S. firms, import these chemicals in bulk quantities, process them into dosage forms, and distribute the drug products in domestic and international commerce. Until recently, Canada had no comprehensive chemical control law or system. That shortcoming has undoubtedly facilitated excessive imports of bulk chemicals by Canadian firms from overseas, as well as the diversion and smuggling of pseudoephedrine pills from Canada to the United States.

U.S. law enforcement agencies seized 236 million pseudoephedrine tablets of Canadian origin in 2002 and 206 million Canadian tablets in 2001. Law enforcement authorities have also discovered 1,000- and 23,000-count bottles and 80,000-count buckets of Canadian pseudoephedrine tablets in large West Coast methamphetamine labs operated by Mexico-based criminal groups. Additionally, recent seizures have yielded unprocessed pseudoephedrine powder, as well as ephedrine tablets,

which are used interchangeably with pseudoephedrine tablets in the clandestine production of methamphetamine.

In 2003, Canada took steps toward a more effective chemical control system. The Precursor Control Regulations, effective in January 2003, impose registration, licensing, and import/export permit requirements, all administered by the Canadian Health Ministry, commonly known as "Health Canada."[62] Law enforcement authorities have noted a sharp decrease in seizures of some precursors from Canada, particularly pseudoephedrine, since a series of arrests were made as part of Operation Mountain Express (discussed in detail in the Law Enforcement section, below). The new Canadian Precursor Control Regulations may have also contributed to this positive trend.

Concurrently, perhaps due to the increased law enforcement focus on pseudoepehdrine, increases have been observed in the amount of ephedrine imported into Canada and in ephedrine seizures along the U.S.-Canada border. This suggests that bulk pseudoephedrine movements from Canada supporting methamphetamine production may have been partially replaced by bulk ephedrine shipments. For example, law enforcement personnel intercepted a 600-pound load of bulk ephedrine near Detroit in May 2003. Authorities in Canada and the United States will continue to monitor the results of the latest Canadian regulations.

Nonetheless, traffickers may be shifting their chemical diversion efforts and manufacturing operations south to Mexico. In March and April 2003, authorities made four large seizures totaling 22 million pseudoephedrine tablets from Asia destined for Mexico, and dozens of similar, prior shipments were identified. Mexican press reports of clandestine lab discoveries signal an apparent increase in methamphetamine production, especially in the Mexicali/Tijuana area.

Since May 1996, the U.S. and Mexico have worked formally through a Bilateral Chemical Control Working Group, which meets as needed to exchange information on regulatory systems and shipment data, to discuss possible joint initiatives, and to share case information. The current Mexican government has shown revitalized interest in cooperation against the diversion of chemicals as well as pharmaceutical drugs. DEA is now working to help Mexican law enforcement officials to identify and seize clandestine methamphetamine labs, and to investigate and prosecute the associated chemical and drug traffickers.

On the multilateral front, DEA has encouraged international consensus for voluntary, informal, flexible, and rapid systems of international information exchange on precursor chemical shipments. For example, under the Multilateral Chemical Reporting Initiative (MCRI), countries report chemical transactions on a single form, using the International Narcotics Control Board (INCB), a UN-based body, as a clearinghouse. In an effort targeting synthetic drugs in particular, Project PRISM was initiated in 2002 in a meeting sponsored by the INCB and hosted by the United States and EU. This operation involves some 38 countries that are major manufacturers, exporters, importers, or transit countries of chemicals diverted to synthesize amphetamine-type stimulants, such as MDMA/Ecstasy and methamphetamine. The initiative assists governments in developing and implementing operating procedures to more effectively supervise trade in the precursors of amphetamine-type stimulants in order to prevent diversion.

DEA also conducts one- and two-week training seminars on Clandestine Laboratory and Precursor Chemical Diversion Investigations and is coordinating an eleven-country initiative with countries in the Far East to prevent the diversion of MDMA precursor chemicals. In addition, DEA is working directly with host nations through their attaches in key Far East locations, including China, Hong Kong, and Thailand.

The placement of international organizations, particularly the INCB, in lead roles in multilateral chemical cooperation encourages participation by countries that might be reluctant to participate in an operation led by any single country or group of countries. The annual meeting of the UN Commission on Narcotic Drugs is the best, and most visible, vehicle for encouraging the INCB to take a lead role, to shape how it performs that role, and to promote participation by the most relevant countries. Other multilateral organizations, such as the Organization of American States' Inter-American Drug Abuse Control Commission (OAS-CICAD), are also proving instrumental in building regional and international coordination, cooperation, and adoption of harmonized control procedures.

The current international chemical control system is not without shortcomings. It has evolved on an ad hoc basis, drug by drug, chemical by chemical, operation by operation.[63] It is voluntary; some countries do not participate, and traffickers are avoiding controls by shipping to those countries. Also, some countries are more diligent than others in investigating shipments after receiving pre-export notifications. In general, the system, which is flexible and informal by design, would now benefit from becoming more universal, formal, and institutionalized.

In addition, countries apply the 1988 UN Convention provisions variably. For example, some chemical importing countries have not asked the UN for pre-export notification pursuant to Article 12(10) of the Convention. Some critical exporting countries do not impose legal controls on precursor chemicals that are contained in pharmaceutical preparations—a lapse which has permitted the un-notified exportation and diversion of millions of pseudoephedrine pills.[64]

Another obstacle to effective national and international chemical control is that many countries place responsibility for chemical control with health or commerce ministries. The natural tendency of these ministries is to consider chemical control a health or commercial issue, and not a law enforcement issue. Law enforcement agencies are more oriented to exchange information about chemical shipments and to act on suspicious information. (In the United States, DEA has responsibility for both chemical regulation and enforcement).

The United States has been successful at convincing our international partners of the importance of chemical control, stressing the fact that effective domestic control and international cooperation require a viable enforcement component. We have seen other countries build cooperation between their law enforcement agencies and their health and commerce ministries. Diplomatic agreements have also facilitated cooperation between sometimes bureaucratic and turf-conscious ministries. For example, the 1997 chemical control agreement between the United States and the EU has been instrumental in facilitating our cooperation with individual EU member law enforcement agencies, despite the fact that responsibility for chemical control may rest with health or commerce ministries.

### d. Chemical Control Results

Chemical control has been an area of largely unheralded law enforcement success. Taking together the international, federal, and state measures, combined with voluntary efforts by private industry, chemical control remains a promising, proactive approach to disrupting synthetic drug production and trafficking.

One way to track success, in chemical control as in other efforts, is to monitor the availability, price, and purity of synthetic drugs. Although data vary over time and by region, methamphetamine prices have generally held steady within a range since 1998. In 2003, methamphetamine sold for $3,000 to $12,000 per pound and $270 to $1,500 per ounce. The market trend is decidedly towards the "ice" or

crystal form of methamphetamine; prices for ice have also been steady since about 2001, a little higher than the non-ice form. Methamphetamine purity trends paint a more sobering picture, for purity has risen steadily since about 1999, as shown in the figure below. However, the data in this chart, showing average purity of drug samples at 60% for the beginning of 2004, should be kept in perspective: purity levels are still well below the 1994 average of 72%.

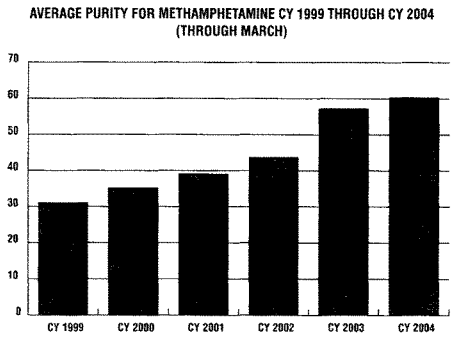



*Figure 23: Bar graph of average methamphetamine purity from 1999 through March 2004 in seized samples. Source: DEA STRIDE seizure data*

On a more encouraging note, chemical prices on the illegal "gray market" have risen in a way that continues to indicate scarcity. A trafficker might pay as much as $4,800 for a case of 144 bottles of pseudoephedrine that has a legitimate market of $1,000. Red phosphorous, used to make hydriodic acid in the "ephedrine reduction" method of methamphetamine production, sells for approximately $500 per pound (approximately 450 grams) on the street, compared to its licit market price of approximately $34 for 500 grams in legitimate commerce. Red phosphorous also sells for about $1 per gram at Internet auction sites.

Overall, the price and purity data suggest that aggressive new approaches may be needed on the regulatory front if the nation is to make additional headway against the problem of methamphetamine production.

### e. Control of OxyContin and Other Diverted Pharmaceutical Products

Controlling the diversion of pharmaceutical products containing controlled substances, including OxyContin, is a shared federal-state responsibility. Federal laws focus on the import, export, manufacturing, and distribution levels. For example, there are federal requirements for tracking transactions from distributors to the retail pharmacy or hospital level and for reporting events that compromise the "closed system" of controlled substance distribution (such as thefts or significant losses). State laws focus on the dispensing level, mostly in pharmacies.

Control of prescriptions and dispensing is primarily a state responsibility. Prescription monitoring programs can enable states to exercise greater control in this area by facilitating the collection, analysis, and reporting of information on the prescribing, dispensing, and use of pharmaceuticals. This

data can be used to alert licensing, regulatory, or law enforcement officials to cases of inappropriate prescribing or dispensing of controlled substances.

The effectiveness of these prescription monitoring programs has already been demonstrated, as explained in the 2004 National Drug Control Strategy. One year after Nevada established its prescription monitoring program in 1997, for example, the number of narcotic drug doses dispensed to suspected abusers was cut by 46 percent. The Strategy also points out that in 2002 the five states with the lowest number of OxyContin prescriptions per capita all had prescription monitoring programs, while the five states with the highest number did not.

Twenty states currently have some form of prescription monitoring program in place, and several others have programs under development. All remaining states should be urged to develop prescription monitoring programs of their own. The National Alliance for Model State Drug Laws (NAMSDL) has created several model programs and can provide support for the evaluation and initiation of drug monitoring programs.

2. Recommendations

**Support Stronger State Controls on Precursor Chemicals:** - (**DOJ**, ONDCP, DEA)
States that face significant levels of clandestine lab activity and chemical diversion are urged to consider the imposition of more stringent controls than those currently in place at the federal level. Several states, notably Oklahoma, have recently enacted strict retail-level controls. (See Appendix F.) Additional state-level controls could include, for example: allowing only licensed pharmacists and pharmacy technicians to sell products containing precursor chemicals; placing such products behind the sales counter and/or in a locked display case; purchase limits imposed on a transaction and/or monthly basis (with an appropriate tracking mechanism); and requirements of customer identification sales record keeping.

**Remove the Blister Pack Exemption:** - (**DEA**, DOJ)
Support legislation that removes the blister pack exemption and eliminates distinctions based on the form of packaging, as recommended in DEA's November 2001 report to Congress.[65]

**Regulate Chemical Spot Market:** - (**DEA**, DOJ)
As an extension of existing authority over imports,[66] law enforcement should seek the legislative authority to regulate sales of bulk chemicals on the domestic spot market by notification and approval of any deviations in quantity or customer from the import declaration.[67]

**Determine Licit Chemical Needs:** - (**DEA**, DOJ, ONDCP)
In cooperation with industry, commission a statistical analysis to estimate the legitimate needs for pseudoephedrine and ephedrine products—including combination products such as ephedrine with guaifenesin—both nationwide and regionally .

**Enable Import Controls on Bulk Ephedrine and Pseudoephedrine:** - (**DEA**, DOJ, ONDCP)
Seek legislation that would treat the post-importation handling of bulk ephedrine and bulk pseudoephedrine in a similar manner, for regulatory purposes, as federal laws now treat the post-importation processing of Schedule I and II controlled substances. Impose such controls on these critical precursors as are needed to limit imports to those necessary for legitimate commercial needs and for maintenance of effective control over chemical diversion.[68]

**Limit Online Chemical Sales:** - (**DEA**, DOJ)
Continue ongoing efforts to advise the owners and operators of major on-line auction websites of the use of precursor chemicals in clandestine labs, and urge them to consider banning the sale of precursor chemicals over their web sites.

**Strengthen Cooperation with Mexico:** - (**DEA**, DOJ, State, ONDCP)
Solidify significant recent advancements by Mexico to increase the effectiveness of bilateral chemical control with the United States through continued partnership and meetings with the pertinent Mexican components, including their drug intelligence center (CENAPI), the Federal Investigative Agency (AFI), the chemical regulatory entity in the Ministry of Health (COFEPRIS) and the Health Commission.

**Enhance Coordination and Information Exchange with Canada:** - (**DHS**, ICE, CPB, DEA)
Enhance ongoing coordination with Canada Customs and Revenue Agency on border detection, targeting, and interdiction efforts, and ensure appropriate focus by Canada-U.S. joint Integrated Border Enforcement Teams on the precursor chemical and synthetic drug threats. Further expand the ongoing exchange of information concerning Canadian businesses involved in the importation, production, and distribution of pseudoephedrine—particularly those firms whose products have frequently been diverted or smuggled into the United States.

**Strengthen the Multilateral Chemical Control System:** - (**DEA**, DOJ, State, ONDCP)
Garner international support for making existing multilateral chemical controls more universal, formal, and well-supported by international institutions, including UN bodies such as the International Narcotics Control Board and regional bodies such as the Organization of American States' Inter-American Drug Abuse Control Commission (CICAD). Work to realize the full potential of Project PRISM, and build support for the application of the 1988 UN Convention to pharmaceutical preparations containing precursor chemicals that can be easily recovered for use in illicit drug production.

**Exchange Information with Chemical Producing Countries:** - (**DEA**, DHS, State, USTR)
Continue ongoing information-sharing efforts with the countries that produce precursor chemicals used to make amphetamine-type stimulants, particularly China, India, Germany, and the Czech Republic.

**Educate Store Employees:** - (**DEA**, DOJ)
Building on efforts begun in a number of states, work to develop a model training program for pharmacists, retail management, and store employees concerning suspicious pseudoephedrine purchases, as well as suspicious sales of chemicals and items used in the manufacture of methamphetamine.[69]

**Encourage Voluntary Controls by Retail Pharmacies and Stores:** - (**DEA**, DOJ, ONDCP)
Seek the voluntary participation of major retail chains in programs to control pseudoephedrine product sales through restrictions on the quantity that can be purchased at a single time. Also support the voluntary movement of pseudoephedrine products from stores' open shelves to behind pharmacy counters or other manned counters in retail settings where pharmacies are not on site.[70]

**Work with Manufacturers to Reformulate Abused Pharmaceutical Products:** - (**DEA**, FDA)
Continue to support the efforts of firms that manufacture frequently diverted pharmaceutical drugs to reformulate their products so as to reduce diversion and abuse. Encourage manufacturers to

explore methods to render products containing key precursors such as pseudoephedrine ineffective in the clandestine production of methamphetamine and pain control products such as OxyContin less suitable for snorting or injection.

**Support State Prescription Monitoring Programs**: - (**DEA**, ONDCP)
Support states' creation of prescription monitoring programs designed to detect inappropriate prescribing patterns and prescription fraud. Law enforcement and regulatory entities should have access to information in case of apparent diversion or inappropriate prescribing of controlled substances, and some provision for state-to-state communication of adverse information should be examined. Supporting legislation should be explored.

## *D. Law Enforcement*

1. Current Efforts

Following the release of the National Methamphetamine Strategy in April 1996, federal law enforcement agencies have launched several initiatives to combat the methamphetamine problem as well as threats posed by other synthetic drugs and diverted pharmaceuticals. Some obstacles continue to hamper fully effective enforcement: lack of properly trained personnel to conduct chemical and lab investigations and seizures; limitations in funding to support such police work and for cleanup of lab sites; and reluctance of some federal and state prosecutors to handle chemical and small lab cases. Steps have been taken, however, to rectify all of these challenges.

DEA has intensified its institutional focus on methamphetamine and other synthetic drugs of abuse, establishing methamphetamine in particular as one of its five priority areas. A new Dangerous Drugs and Chemicals Section has been formed at DEA Headquarters, and more methamphetamine-targeted teams of agents and diversion investigators now work in field offices.[71] Through the Priority Target System, DEA provides funding and operational assistance to chemical and club drug investigations that are designated priority targets within their respective field divisions.

Of particular relevance to investigations of club and predatory drugs, DEA has recently established two new units to support Internet-based investigations. Overall, DEA has implemented a multi-faceted initiative to counter the threat posed by club and predatory drugs through raising public awareness and strengthening law enforcement. This initiative, "Operation X-Out," was started in November 2002, and is ongoing. It is expected to increase the number of club and predatory drug investigations nationwide and raise public awareness of the MDMA problem.

### a. Methamphetamine: Planning and Coordination

The National Methamphetamine Chemicals Initiative (NMCI), along with its component regional groups including the California Precursor Committee, the Tri-State Precursor Committee (Arizona, New Mexico, and Nevada), and the Mountain States Precursor Committee (Colorado, Montana, Utah, and Wyoming), is an active coordinating and training mechanism. NMCI brings together federal, state, and local law enforcement officers, chemists, and intelligence analysts, as well as criminal and civil prosecutors to discuss legal and regulatory issues, trends, and successful strategies that target rogue firms and violators that funnel chemicals to clandestine laboratories.[72]

Over the past four years, the NMCI has established working groups to address important issues, including Canadian pseudoephedrine, the domestic iodine diversion problem, iodine smuggling

from Mexico, the need to regulate red phosphorous and related chemicals (which has been accomplished), and voluntary initiatives with industry to reduce diversion from stores. As a result of the recent arrests of a number of people associated with a treatment, storage, and disposal facility in Arizona, the NMCI created a task force composed of federal, state, and local officials in multiple states to address the potential diversion of hazardous chemicals from hazardous waste contractors.[73] The NMCI has also supported the creation and dissemination of a training video for law enforcement and utility personnel that explains the hazards associated with clandestine drug labs.

HIDTA partnerships are also responsive to methamphetamine trafficking concerns. In particular, the Midwest HIDTA focuses on the investigation and reduction of methamphetamine production and distribution in an area covering six states (Iowa, Kansas, Missouri, Nebraska, North Dakota, and South Dakota). HIDTA funds also support NMCI activities.

Local agencies handle the majority of synthetic laboratory investigations, and some states are performing their own cleanups. In the appropriations for the Department of Justice in both 2002 and 2003, DEA was allocated $20 million to help state and local law enforcement clean up clandestine labs.[74] DEA is implementing contracts nationwide to provide cleanup services for DEA as well as state and local law enforcement agencies. DEA and the Environmental Protection Agency (EPA) are also working together to redraft guidelines for cleaning up clandestine drug laboratories.

### b. MDMA: Planning and Coordination

The Department of Homeland Security's Bureau of Immigration and Customs Enforcement established the National Ecstasy Task Force to serve as a command-and-control center for coordinating MDMA interdiction and investigation efforts, and also to collect actionable intelligence on developing patterns and trends for dissemination to the field. Increased border interdiction efforts have resulted in the identification and investigation of large-scale MDMA smuggling organizations in the United States as well as in Europe. Conducted jointly by DEA, foreign law enforcement entities, and state and local agencies, these investigations have resulted in significant seizures of MDMA and other synthetic drugs and currency, both at and away from border areas, and have led to the arrest of organization members at all levels.

In addition, the 28 HIDTA regional partnerships between federal, state, and local law enforcement officials are evaluating the MDMA threat in their respective regions. In cases where the MDMA threat is judged to be significant, appropriate shifts in enforcement strategies are being made.

On the international level, bilateral meetings in March 2003 between the United States and the Netherlands yielded an action plan for enhancing law enforcement and judicial cooperation on drugs, crime, and terrorism. The two countries are now working actively and cooperatively to implement these plans. Results have included the exchange of information on U.S. and Dutch judicial systems; collaboration with U.S. law enforcement agencies on more investigations; exchange of information on MDMA seizures; Dutch development of a risk indicator and profiles for targeting traffickers; creation of a bilateral discussion group on demand reduction; and cooperation internationally in the framework of the INCB Project Prism.

### c. Training

Training efforts have gone forward on several fronts. The NMCI has conducted training on the topics of chemicals investigation and prosecution for hundreds of federal criminal and civil prosecu-

tors, intelligence analysts, and federal, state, and local officials. The Department of Justice's Bureau of Justice Assistance has also funded methamphetamine-related training programs for state and local officials. DEA has intensified its domestic training efforts by offering Clandestine Laboratory Safety Schools and OSHA-certified training to federal, state, and local law enforcement officers. Since 1998, DEA has provided OSHA-certified lab training to over 4,174 police officers throughout the nation, along with approximately $2,500 in equipment for each trainee. As part of the basic drug training course, all new DEA and FBI agents receive training concerning MDMA and other "club" and "predatory" drugs like GHB. MDMA is also covered in the training that DEA offers each year to approximately 300 state and local investigators at the Drug Unit Commander's Academy and to about 150 law enforcement executives at the FBI National Academy. In addition, DEA's Chemical Control Section has trained hundreds of foreign officials in more than two dozen countries on the diversion and smuggling of all chemicals used in illicit drug production.[75]

### d. Seizures, Investigations, and Prosecutions

The ready availability of pseudoephedrine from Canada largely mitigated any temporary scarcities and higher "gray market" prices for pseudoephedrine and illicitly produced methamphetamine. DEA-led enforcement initiatives against "rogue" chemical firms, particularly "Operation Mountain Express" in the summer of 2000, have been extremely effective at countering this illicit chemical flow. A follow-on "Operation Mountain Express" targeted traffickers who illegally smuggled pseudoephedrine from Canada, and culminated in January 2002 with the arrests of over 130 defendants and the seizure of 35.8 tons of pseudoephedrine.

In April 2003, another joint investigation—"Operation Northern Star"—resulted in the arrests of, among others, six executives of three Canadian chemical companies that manufactured bulk pseudoephedrine in Montreal. The drugs were stockpiled in Ottawa, then smuggled across the border to methamphetamine manufacturers in the United States. The Royal Canadian Mounted Police and DEA were the lead agencies in this investigation, which ultimately produced arrests in 10 cities and charges against the three Canadian chemical companies involved.[76]

The progress of CBP and ICE border seizure initiatives also continues. Authorities at the U.S.-Mexico border seized two tons of iodine in both 2001 and 2002. Similar seizure rates were reported in 2003 as well.

Moreover, the Department of Justice has enhanced prosecution efforts for all synthetic drugs, particularly methamphetamine and club drugs. The number of Organized Crime Drug Enforcement Task Force (OCDETF) cases focusing on methamphetamine has increased in recent years, both in absolute numbers and as a percentage of all OCDETF cases. Law enforcement agencies are devoting more resources to club drug investigations as well. One prominent investigation, "Operation Webslinger," was a multi-agency effort targeting the illegal Internet trafficking of GHB and its analogues, GBL and 1,4-butanediol. Culminating on September 19, 2002, the operation led to the arrest of more than 130 defendants in over 100 cities and the seizure of more than 25 million dosage units. DEA agents more than tripled their work hours on club drug cases between 1999 and 2001 (to over 250,000) and also made more than three times as many arrests for club drug offenses in 2001 (1,929 arrests) as in 1999 (577 arrests).

The number of defendants sentenced on federal MDMA trafficking charges has also climbed from 117 defendants in 1999 to 372 defendants in 2001, which is the last year for which data are available.[77] However, there have been a number of notable federal MDMA cases since the beginning

of 2001. In August 2001, 55 people were arrested, including the leader of a poly-drug ring, in connection with the distribution of "green clover" MDMA tablets in Colorado; one of the tablets caused the widely publicized death of a 16-year-old girl. An MDMA and methamphetamine lab in California capable of producing millions of tablets was seized in October of 2001, and 20 people associated with the organization were arrested. Several large-scale MDMA traffickers from Israel, including the leader of the world's largest MDMA smuggling ring, were arrested in 2002. In addition, an MDMA smuggling ring operated by Dominican nationals in New York and the Netherlands was disrupted in November 2002 through the arrest of 20 traffickers within the organization.[78] Most recently, Operation Candy Box, a joint U.S.-Canada effort, netted arrests in March 2004 of more than 130 people associated with a large organization that manufactured and trafficked MDMA and marijuana.

Federal authorities have also had success pursuing rave venues and promoters under the federal "crack house" statute[79] for conduct that facilitates the trafficking of club drugs. In 2000 a DEA investigation and raid of the State Palace Theater in New Orleans contributed to a 90 percent drop in MDMA overdoses in that city. Investigations in the Boise, Idaho, area into the sale of MDMA, ketamine, and other drugs led to convictions of 30 people on trafficking charges, including a rave promoter who pleaded guilty to crack house charges. A New York state rave promoter was also charged under the crack house statute in November 2002.

Finally, local law enforcement personnel have discovered that conducting reverse buys of precursor chemicals from suspects has limited the amount of pseudoephedrine on the streets. In these cases, undercover officers use confiscated pseudoephedrine and attempt to engage precursor traffickers and methamphetamine producers in buying the product for illicit purposes. Arrests and leads allow law enforcement to continue to build upon these investigations by locating synthetic labs. Southern California law enforcement agencies credit this tactic with bringing about the recent reduction in the number of local synthetic drug labs.

2. Recommendations

**Target Pseudoephedrine and Iodine Smuggling to and from Mexico:** - (**DEA**, ICE, CBP)
Focus resources on stopping the recently noted flow of suspicious shipments of precursor chemicals, notably pseudoephedrine, from Asia to Mexico, apparently destined for clandestine methamphetamine labs in the U.S. and Mexico. Also focus on the smuggling of iodine from Mexico. In all such cases, law enforcement should identify and aggressively pursue the persons and firms responsible .

**Focus on Canadian Synthetics and Chemical Smugglers:** - (**DEA**, ICE, DOJ)
Expand joint U.S.-Canadian investigations into the smuggling of chemicals, methamphetamine, MDMA, and other club drugs and diverted pharmaceuticals. Assign high priority to investigations of large seizures of pseudoephedrine and ephedrine from Canada, and develop prosecutable cases against rogue Canadian companies and their principals.

**Investigate Ties between Canadian and Mexican Criminals:** - (**DOJ**, DEA, ICE, NDIC)
Analyze law enforcement reporting and intelligence with respect to Canadian pseudoephedrine and ties between Canadian sellers and Mexican lab operators in California. Analysis of the flow of funds generated from sales of pseudoephedrine in Canada and the United States should be coordinated by the appropriate agencies within the concerned Departments.

**Investigate Asian and European Sources of Synthetic Drugs:** - (**DEA**, ICE, State)
Work with international law enforcement partners and regional groups to investigate Asian criminal groups in North America and in Asia that increasingly may be engaged in producing and trafficking synthetic drugs and their precursor chemicals. Enhance bilateral efforts with the Netherlands and other MDMA-producing countries in Europe to build investigations, share information, and extradite criminals where appropriate.

**Enhance Methamphetamine Profiling Efforts:** - (**DEA**, DOJ, ONDCP)
Increase the number of samples available for analysis in DEA's methamphetamine profiling program by incorporating samples of the drug seized by state and local law enforcement at super labs, or from shipments strongly suspected of originating from such large-scale operations. Also leverage information on chemicals, adulterants, cutting agents, and equipment found at the sites.

**Review Lab Cleanup Resources:** - (**DEA**, DOJ, EPA)
Ensure adequate funding sources for clandestine laboratory and dumpsite cleanups, including funding for sufficient personnel to support laboratory cleanups and hazardous waste disposal, so that cleanup costs are not a disincentive to laboratory investigations or takedowns. Federal officials, in collaboration with state agencies, should conduct a needs assessment to identify potential program improvements and make recommendations on the specific support needed and the funds required.

**Apply Updated Clandestine Lab Cleanup Guidelines:** - (**DEA**, EPA)
Disseminate and apply the latest guidelines for the cleanup of clandestine methamphetamine labs and, where necessary, coordinate environmental remediation by appropriate entities. These protocols for adulteration and destruction of precursor and essential chemicals, glassware, and methamphetamine waste should be part of clandestine laboratory certification training.

**Increase Prosecutor and LEA Training:** - (**DOJ**, DEA, CBP)
Recognizing the unique issues presented by chemical and methamphetamine cases, the Federal Government should, as resources permit, offer training for criminal and civil prosecutors and federal, state, and local law enforcement agents more frequently and in different regions of the country.

**Make Full Use of Charging and Sentencing Options:** - (**DOJ**, DEA)
Prosecutors should make full use of federal Sentencing Guidelines provisions which set a sentencing floor (of 70-87 months) for any case involving methamphetamine manufacture that creates a substantial risk of harm to human life.[80] Federal prosecutors should also make greater use of the environmental enhancement for clandestine drug manufacturing involving "unlawful discharge, emission, or release into the environment of a hazardous or toxic substance or for the unlawful transportation, treatment, storage, or disposal of a hazardous waste".[81]

**Increase Access to Civil Penalty Case Experts:** - (**DOJ**)
The Department of Justice should develop and disseminate a list of attorneys who have experience in civil penalty cases under the Controlled Substances Act and are available to assist U.S. Attorney's Offices in districts where such cases have never or rarely been referred or pursued.

**Prevent Exploitation of Mail Services:** - (**DEA**, CBP, ICE, State, NDIC, FDA)
Work with the U.S. Postal Service and private express mail delivery services to target illegal mail-order sales of chemical precursors, synthetic drugs, and pharmaceuticals, both domestically and internationally .

**Improve Intelligence Efforts Related to Synthetic Drugs:** - (**NDIC**, DEA, CIA, CBP, ICE, State)
Intensify intelligence components' focus on gathering and sharing information regarding the nature and scope of synthetic drugs trafficking. Make full use of NDIC's real-time analytical database for both pre- and post-operation link analysis and document exploitation. Strengthen mechanisms for sharing actionable intelligence, trend analysis, and information on criminal organizations among the United States and concerned Western European countries.

**Target Raves Where Drug Use is Facilitated:** - (**DEA**, DOJ)
Focus attention on the promoters and operators of rave events that facilitate the trafficking and abuse of MDMA and other club drugs, making innovative and effective use of the federal "crack house" statute, including amendments in the Rave Act.

**Consider New Legislation on Club Drugs:** - (**DOJ**, DEA)
Federal officials should continue efforts to develop additional legislation to address legal issues that often arise with respect to club drugs and rave-type events. For example, the distribution of imitation controlled substances could be explicitly criminalized at the federal level, and the provisions governing controlled substance analogues and counterfeits could be clarified.[82]

**Strengthen Controls on Internet Sales:** - (**DOJ**, DEA)
Support legislation that regulates the burgeoning business of Internet sales of drugs, particularly controlled substances, by prohibiting the dispensing of controlled substances online without a valid prescription. The new law would define a valid prescription as one issued for a legitimate medical purpose in the usual course of professional practice, and would require at least one in-person medical evaluation by the prescribing doctor.

**Increase Internet Investigations:** - (**DEA**, DOJ, NDIC, ICE, FDA, State)
Expand investigations and prosecutions of Internet-based synthetic and illegal pharmaceutical drug diversion and sales, to include the establishment of task forces and coordination mechanisms dedicated to this purpose. Agencies should work with Internet Service Providers to assist them in limiting children's access to illegal drug sites.

**Target OxyContin and Vicodin Diversion:** - (**DEA**, DOJ)
Support efforts to target individuals and organizations involved in the diversion, illegal sale, pharmacy theft, fraud, and abuse of OxyContin and other drug products containing oxycodone or hydrocodone, such as Vicodin and Lorcet.

**Seek Updated Sentencing Guidelines for Club Drugs:** - (**DEA**, DOJ)
Work with the U.S. Sentencing Commission to review data on the impact and effectiveness of current sentences for trafficking in ketamine, GHB and its precursors and analogues, and other club drugs, and, if advisable, propose enhanced guidelines sentences.

**Share Law Enforcement Best Practices:** - (**DEA**, DOJ)
Based on the successes achieved by local law enforcement in Southern California using reverse-buy investigations and by communities in the Midwest that have set more strenuous penalties and regulations regarding synthetic drugs, establish a mechanism for sharing best practices among federal, state, and local law enforcement as well as with international partners who are confronting synthetic drug threats.

# Appendix A:

## Outline of an Early Warning and Response System for Emerging Drugs of Abuse

Participants in all aspects of drug abuse control efforts—whether on the "demand" or "supply" side—have sometimes complained of being caught off guard by the apparently sudden emergence of new drug abuse trends in the United States. Recent examples include MDMA ("Ecstasy") and GHB (one of the "date rape" drugs). This phenomenon occurs despite the existence of several sophisticated and comprehensive data systems by which drug abuse is measured across the country. This outline of an "early warning" template and a means of first response is an effort to address this problem.

The model portrayed in this Appendix is not intended to dictate any specific agency action, but rather to give structure to the government's system of detecting and responding to new trends. Consistent with their respective missions, many governmental agencies, acting individually and in collaboration, already undertake several of the activities discussed in this outline.

I. Identification of an "emerging drug problem." *("How do we know there's a problem?")*

**Step A.** Intensive, selective sampling of specific data sources is most likely to yield a reliable "early warning" of a new drug threat.

Discussion of data systems:

- The objective: A system that yields rapid data with a scope as comprehensive as possible.
- Current national data systems tend to emphasize accurate ("cleaned") and complete data over speed, so lag time is excessive for an "early warning" alarm.
- The idea behind the quantitative and qualitative data gathering activities outlined below is to produce a "quicklook" or "sentinel" product to support earlier government intervention if warranted by selected trend information. The format and process of transmitting such information could take the form of brief, informal, periodic (e.g., quarterly or mid-year) reports.
- The types of data that are most pertinent for an early warning system include data on:
  (a) current use (versus treatment visits, drug deaths, perceived harm)
  (b) new or growing drugs of abuse (versus cocaine, heroin, etc.)
  (c) groups most likely to use new drugs (e.g., young people and "marginal" groups)

Recommendations: Existing data-gathering efforts should be honed to selectively harvest the most useful early warning data. In this regard, the following data sources should be explored:[83]

- Quantitative: Sample the following data sources more intensively and frequently—yet more selectively, both in terms of geographic distribution and drugs of interest—for signs of emerging drug abuse:
  - ➤ Tap into state/local and federal (DEA) forensic lab data. There are two real-time forensic data systems. The National Forensic Laboratory Information System (NFLIS) collects

results of drug analyses from state and local forensic labs across the country. The federal equivalent is the DEA System to Retrieve Information from Drug Evidence (STRIDE).[84] It would be useful if all labs were encouraged to analyze samples of non-controlled substances, which might warrant DEA scheduling as drugs of abuse.

- ➤ Selectively expand collection of ADAM data. The DOJ/NIJ-administered Arrestee Drug Abuse Monitoring program (ADAM) reaches the high-risk drug population of people arrested and booked in NIDA data sites, but data are limited to the five most commonly used drugs. Selected sites could expand interviews and urinalyses to capture other drugs and trend information.
- ➤ Emergency Room (ER) data. The recently re-designed DAWN holds particular promise in providing early warning for drugs of abuse. It will include the capacity for real-time access and online queries of DAWN data; other sophisticated approaches to detection and information delivery are planned.
- ➤ CDC data: The Center for Disease Control is developing a methodology to identify incidents of poisoning. Part of this effort is to monitor regional trends of consumption of certain types of over-the-counter medications. This information could be used as one tool to indicate surges in the abuse of certain commonly available drugs or the diversion of products such as pseudoepehdrine for methamphetamine production.
- ➤ High school survey. For example, there could be a way to advance the survey process and data analysis of selected schools in the Monitoring the Future survey.

- Qualitative:
  - ➤ Seek public input through an Internet-based vehicle, e.g., by linking a reporting website with the websites of professional organizations for emergency room and addictions personnel, law enforcement, and teachers. (See S. 151 § 323 (108th Cong.), authorizing a "cyber tipline")
  - ➤ Regularly cull data from . . .
    - Internet chat rooms
    - Ethnographers who have contact with drug users
    - College campus health clinics
    - Faith organizations with a focus on cities and towns which have in the past proven to be harbingers of emerging drug problems.[85]

**Step B.** Report findings to a designated "interagency early warning committee." Two inter-disciplinary entities currently serve an early-warning function; either could be adapted to suit this role more effectively.

- The Interagency Committee on Drug Control (ICDC) meets monthly to discuss emerging drug problems and consider responses. The ICDC involves the ONDCP, NIDA, FDA and DEA. The frequency of its meetings commends this group to being the early warning coordination body, but it may need to be expanded—and staffed—to perform this function better.
- The Community Epidemiology Working Group (CEWG) meets semi-annually to assimilate drug-related quantitative and qualitative data from multiple sources and provide current descriptive and analytical information.

II. Rapid analysis of the problem and follow-up on initial discovery. *("Now that we know there's something new out there, how do we determine how big it is and how we are equipped to address it?")*

Discussion of "rapid analysis" stage: Some further efforts to analyze the problem presented by a newly discovered drug threat are critical; however, these should not be undertaken at the expense of considering appropriate responses. The most critical steps are included here.

**Step A.** Do we have the capacity to measure the problem?

- Data problems: Do we have the right survey and other tools to measure this drug problem? If not, can they be adapted? (Example: If it is primarily a drug used by the rural working poor, do we need to ramp up a means of measurement?)
- Detection problems: Can the drug be detected; by what means; and are those means adequate?

If current testing means are inadequate, foster the development and validation of new drug-detection tests and tools; disseminate methods and materials. Secure assistance and expertise from government, academia, assay and instrument manufacturers, clinical and forensic pathology, toxicology and their support laboratories.

**Step B.** What is our "first take" on the main characteristics of the problem?

- Demographics of abuse: age; gender; race or ethnic group; socioeconomic group; geographic impact; urban, suburban, or rural
- Degree of danger to public health and safety
  - short-, medium-, and long-term physiological and psychological effects and dependence profile
  - related social harm or criminal conduct (e.g., drug-seeking crime, domestic violence, or sexual assault)
  - "gateway" potential
- Sources of the drug; domestic and foreign manufacturing processes, including chemicals used; smuggling methods; distribution routes; diversion from licit pharmaceutical supplies
- Production/trafficking organizations and their financial structures
- Public awareness and attitudes
- Treatment protocols
- Are there unique and pressing research needs in any of these areas?

III. Response *(Now that we know there's a problem and have an idea of its scope and dimensions, what are we going to do about it?)*

**Step A.** Assess response and structure of current system to address problem.

**Step B.** Recommend additional or novel approaches.
For both steps, the following areas of inquiry are pertinent.

1. Awareness. Is the awareness level adequate? Is greater awareness desirable? If answers are "no" and "yes" respectively, how best to raise awareness? (Examples: Government and NGO websites; media campaigns including ads and public service announcements, etc.)

2. Prevention and Education
   a. Canvass HHS components (e.g. NIDA, SAMHSA), Dept. of Education, state and local prevention groups, and NGOs to determine whether current prevention efforts are adequate, or might be easily adapted, to address the problem.
   b. If not, devise a new approach.
3. Treatment
   a. Assess our knowledge of acute and long-term treatment through emergency rooms and addiction treatment programs.
   b. If inadequate, how might we develop better treatment protocols?
4. Regulatory
   a. Is the substance scheduled? Does it need to be scheduled or placed on a higher schedule? Does it need and qualify for temporary, "emergency" DEA scheduling?
   b. Are there "immediate precursors" (as defined under the CSA); if so, should they be scheduled as such?
   c. Are there precursor or essential chemicals that should be brought under control as "listed chemicals"?
   d. Are there analogues that should be treated as the same substance?
5. Legislative
   a. Are current laws—both federal and state—adequate to address the problem? If not, what law reform is needed?
   b. Do current sentences appropriately reflect the seriousness of trafficking of the substance? If not, what adjustments are advisable?
6. Law enforcement
   a. Is there anything special about this drug or drug trend that requires a different law enforcement approach
      - by police or prosecutors; or
      - at the federal, state, or local level?
   b. If so, what new actions are needed?
7. International
   a. Does the problem have international dimensions?
   b. If so, what approaches would be effective through:
      - multilateral drug control entities (e.g., UN-based, such as INCB);
      - regional bodies (OAS-CICAD); and
      - bilateral approaches, if there is a manageable number of key foreign countries with whom we have working relationships?

# Appendix B:

## Overview of the New Drug Abuse Warning Network (DAWN) System Design and Implementation

### Summary

The new Drug Abuse Warning Network (DAWN) is designed to provide real-time access to sentinel event data that will be used by participating facilities, clinicians, communities, and policy makers. In addition, it is designed to provide improved national and metropolitan estimates of drug-related emergency department (ED) visits and drug-related deaths investigated by medical examiners and coroners (ME/Cs). Expansion of DAWN's geographic coverage and case criteria will provide more complete and comprehensive surveillance of drug-related events. Deployment of the Sentinel Event Reporting System (SERS) will provide authorized users with real-time query access to DAWN records to detect emerging trends and new drug problems before they become widespread.

### DAWN: Creation of a Warning Network

Following a 20-year evaluation of design alternatives and user needs, the Drug Abuse Warning Network (DAWN) has been redesigned. The new design, with a multi-year implementation schedule that began in 2003, is focused on accomplishing two goals:

> **Goal 1:** Provide better national and metropolitan-area estimates of drug-related emergency department (ED) visits and drug-related deaths investigated by medical examiners and coroners (ME/Cs).
>
> **Goal 2:** Become an active surveillance network with the ability to identify aberrant trends in known drug problems, detect new drug problems before they become widespread, and quickly make this information available to hospitals, clinicians, communities, and policy makers.

While the first goal represents and enhancement of DAWN's traditional analytical capabilities, the second is new. This goal will be achieved through completely new capabilities that will make the "warning" in DAWN's name a reality for the first time.

Multiple features of the new DAWN support this goal:

1) DAWN is moving to complete electronic data collection. Data submitted electronically can be edited and cleaned on input, and then made available immediately for real-time queries and analysis.

2) Expanded DAWN case criteria now capture all types of drug-related ED visits and deaths, and revised data items capture more meaningful information about these events. Previously, many relevant drug-related events were missed by restrictive case criteria (for example, cases of drug-facilitated rape became reportable with the new design in 2003).

3) The geographic coverage of DAWN is expanding. When the expansion is complete, DAWN will cover the 48 most populous metropolitan areas across all regions of the United States with both hospital samples and ME/C jurisdictions. In addition, selected statewide ME systems will supply data on drug-related deaths for areas lacking in metropolitan coverage and where hospital samples are not feasible. Although data from ME/Cs will continue to lag behind data from hospitals in timeliness, expansion of the DAWN mortality component in target metropolitan areas and states will augment the ED data with an enhanced picture of the most severe consequences of drug abuse.

4) The Sentinel Event Reporting System (SERS) will be the real-time messenger for the DAWN warning network. SERS is being developed to query DAWN data, identify emerging trends in drug abuse, and supply timely information back to hospitals, clinicians, communities, and policy makers. SERS, which will allow users to access data in real-time without delays for statistical weighting or manipulation, is being deployed in stages.

   Each of the SERS capabilities for querying ED data will have a counterpart for mortality data. Further enhancements will be designed and deployed based on user acceptance and information needs. Access rights will be limited as necessary to comply with statutory prohibitions against disclosure of identifiable information.

# Appendix C:

## DEA Action Plan to Prevent the Diversion and Abuse of OxyContin®

### SUMMARY

In response to growing concern among federal, state and local officials about the dramatic increase in the illicit availability and abuse of the prescription drug OxyContin®, the Drug Enforcement Administration (DEA) has embarked on a comprehensive effort to prevent its diversion and abuse.

The pharmacological effects of OxyContin®, a brand name formulation of the Schedule II narcotic oxycodone, make it attractive to abusers as it offers reliable strength and dosage levels and may, in some instances, be covered by the abuser's health insurance. Abusers have discovered that the controlled release formula of OxyContin® can be easily compromised allowing inhalation or injection for a powerful, morphine-like high.

Reports of the diversion and abuse of OxyContin® are currently concentrated in rural areas of the eastern United States; however, DEA's Office of Diversion Control has identified this activity as a growing problem throughout the nation.[1] It has been described by some local law enforcement officials as a national epidemic in the making. National indicators such as DAWN (Drug Abuse Warning Network) and STRIDE (System to Retrieve Information from Drug Evidence) show recent increases in oxycodone overdoses and law enforcement encounters. Some jurisdictions report as much as a 75% increase in property and other crimes that they specifically attribute to the abuse of OxyContin®. Tazewell County, VA, estimates that OxyContin® addiction is behind 80% to 95% of all crimes committed there.

Criminal activities resulting from the abuse of OxyContin® are quickly depleting the resources, financial as well as human, of local law enforcement. Some states, such as Maine, Virginia and Kentucky, have become so alarmed by this problem that they have begun to take extraordinary action to deal with it. Officials in Kentucky are utilizing a powerful new tool called KASPER (Kentucky All-Schedule Prescription Electronic Reporting), a database of all controlled substances dispensed by Kentucky pharmacists, in their investigations of OxyContin® -related crime.[2] The Attorney General of Virginia recently convened a meeting of officials from five states to discuss ways to halt illegal trafficking in OxyContin®.

### THE PROBLEM

OxyContin® is a Schedule II controlled release form of the narcotic oxycodone manufactured by Purdue Pharma L.P. in 10mg, 20mg, 40mg, 80mg, and 160mg tablets.[3] The controlled release method

---

[1] Data from the Office of Diversion Control Quarterly Reports indicate that OxyContin® has risen dramatically in recent months in terms of mention by the field offices as a 'most abused' drug.

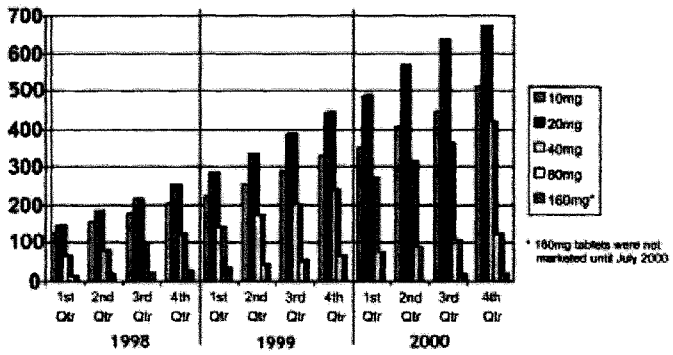
[2] Article published in the Louisville, KY, *The Courier-Journal*, February 8, 2001

[3] After this report was drafted, Purdue Pharma L.P. announced an indefinite suspensions of the distribution of OxyContin® in the 160-mg form.

of delivery used in OxyContin® allows for a longer duration of drug action and, consequently, the manufacture of tablets containing larger doses of the active ingredient. It is legitimately used as a medication to treat moderate to severe pain and is becoming the drug of choice in many pain management clinics. In a little over four years, sales have reached $1 billion.

**Table 1** shows the dramatic increase in the number of OxyContin® prescriptions from 1998 through 2000.

**Table 1: Total OxyContin® Prescriptions (x 1000) Expressed by Dose[1]**




Oxycodone has been marketed in combination products with aspirin and acetaminophen (Percodan® and Percocet®) for many years. Diversion and abuse of these products continue. However, because they contain these other ingredients and only 5 to 10mg of oxycodone, they are primarily abused orally. While prescriptions for oxycodone combination products have increased during the period from 1996 to 2000, prescriptions for oxycodone single entity products (such as OxyContin®) have increased over fourteen-fold.

OxyContin® has become a target for diverters and abusers of controlled substances because of the larger amounts of the active ingredient in relation to other previous oxycodone products and the ability of abusers to easily compromise the controlled release formulation. Simply crushing the tablet can negate the timed effect of the drug, enabling abusers to swallow, inhale, or inject the drug, which is water soluble, for a powerful morphine-like high.

Common means of OxyContin® diversion are fraudulent prescriptions, doctor shopping, over-prescribing, and pharmacy theft. There have been many instances of pharmacies being robbed strictly for their supply of OxyContin®. Investigations have uncovered organized rings of individuals diverting, selling, and abusing OxyContin®. Intelligence has also shown that foreign diversion is another source of the OxyContin® being sold and used illegally in the United States.

## OBJECTIVE

Continued increases in the diversion and abuse of OxyContin® are considered likely unless firm and immediate action is taken. It is the goal of this action plan to reduce the existing and potential costs to public health and safety by having a significant and immediate impact on the diversion and abuse of OxyContin®.

## ACTION PLAN

In order to combat the serious and growing problems stemming from the diversion and abuse of OxyContin®, DEA has developed a four-part action plan. The elements of the plan are as follows:

**1) Enforcement and Intelligence:** DEA must focus existing resources and management attention on investigations of the diversion and abuse of OxyContin®. These investigations require coordination and support from enforcement, diversion, and intelligence groups. Coordinated operations have been initiated in field offices to target individuals and organizations involved in the diversion, illegal sale, pharmacy theft, fraud, and abuse of OxyContin®. DEA is using all available enforcement tools to disrupt these illegal operations. This includes interagency efforts on the federal, state, and local levels and extends to the international as well as the domestic arena.

DEA is continuing to identify large volume purchasers of OxyContin® for referral to field offices for appropriate action. All exports of OxyContin® are being closely scrutinized in order to detect possible diversion trends, particularly in those countries having limited controls on pharmaceutical products.

A complete assessment of the scope and magnitude of OxyContin® legitimate use and abuse is being undertaken utilizing traditional and novel data sources. DEA has initiated contact and continues to work with the National Institute on Drug Abuse, the Substance Abuse and Mental Health Services Administration, the National Institute of Justice, and others to modify data sources (e.g., the Monitoring the Future survey) to improve the specificity of the data collected to reflect OxyContin® abuse.

**2) Regulatory and Administrative:** DEA is utilizing its full range of regulatory and administrative authority to pursue action as necessary to prevent the diversion and abuse of OxyContin®. In doing so, it is essential that DEA elicit the support of other regulatory agencies. These actions are not intended to impact on the availability of legitimate drug products for medical use.

DEA continues to examine the rapid increase in the requested levels of oxycodone quota by the manufacturer of OxyContin®.

DEA continues to work closely with the Food And Drug Administration (FDA) in strongly urging the rapid reformulation of OxyContin® to the extent that it is technically possible, in order to reduce the abuse of the product, particularly by injection. Additionally, both agencies will continue monitoring practices that may contribute to diversion or abuse.

DEA continues to work with the Interagency Narcotic Treatment Review Board and the Federation of State Medical Boards to develop further cooperation on such issues as physician education on the treatment of pain, the recognition of addiction, and implementation of the Federation's Model Guidelines on Pain Treatment.

DEA will pursue legislative initiatives to assist states with funding for prescription data collection and analysis.

**3) Seek Industry Cooperation:** DEA continues to stress the importance of voluntary cooperation from industry in adhering to the spirit and substance of existing law and regulations. The agency is increasing its cooperative efforts with all levels of industry in order to stem the abuse and diversion of OxyContin®.

The cooperation of Purdue Pharma L.P., the sole manufacturer of OxyContin®, is integral to the success of DEA's Action Plan in preventing the abuse and diversion of OxyContin®.

Purdue Pharma has been encouraged to develop a balanced marketing strategy that ensures appropriate use of OxyContin®. Purdue agrees that OxyContin® should be prescribed only to patients where use of an opioid is appropriate for moderate to severe pain lasting more than a few days. Moreover, OxyContin® should be prescribed only by physicians who are knowledgeable about the use of opioids in the treatment of pain. Purdue Pharma will be encouraged to support and provide educational programs alerting legitimate patients as well as the general public to the dangers inherent in the abuse of such drugs.

In order to assist in identifying sources of diversion, DEA proposes that Purdue Pharma modify the shape, indicia, and color of OxyContin® tablets manufactured for export from the United States.

DEA is working with medical organizations and institutions, government agencies, and international health care groups to better assess the legitimate medical needs for narcotic analgesics including OxyContin®. Such groups include the American Pain Society, American Academy of Pain Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the World Health Organization, and the National Institutes of Health.

**4) Awareness / Education / Outreach Initiatives:** Recognizing the importance of the appropriate use of opioids in the treatment of pain, DEA must work to increase national awareness of the dangers associated with the abuse of OxyContin®. An aggressive, national outreach effort to educate the public, schools, the healthcare industry, and state and local governments on the dangers related to the abuse of OxyContin® will be implemented.

DEA must work proactively with the American Medical Association, Federation of State Medical Boards, National Association of Chain Drug Stores, and National Association of Boards of Pharmacy, among others, to alert the healthcare industry to the growing problems associated with OxyContin® abuse. DEA is enhancing existing public awareness programs, including the Demand Reduction Program and the DEA's public internet web sites, in order to educate the public on the dangers of OxyContin® abuse.

# Appendix D:

## Schedules and Regulatory Controls Applicable to the Subject Controlled Substances

### Overview: Controlled Substance Schedules and Chemical Lists

The Controlled Substances Act, at 21 U.S.C. § 812, establishes five lists, or "schedules," of controlled substances. The criteria for each schedule are based on the potential for abuse and the degree of accepted medical use in treatment. Schedules also consider the degree and likelihood of physical or psychological dependence. Schedule I controlled substances have a high potential for abuse, no currently accepted medical use in treatment in the United States, and lack of accepted safety for use under medical supervision. Schedule II controlled substances have high potential for abuse, currently accepted medical use in treatment in the United States or use with severe restrictions, and abuse may lead to severe physical or psychological dependence. Schedule III controlled substances have lower potential for abuse than those in Schedules I and II, currently accepted medical use, and abuse may lead to moderate to low physical dependence or high psychological dependence. Controlled substances on Schedules IV and V have accepted medical use and progressively lower potential for abuse. While Congress initially placed many substances on the five schedules when it passed the CSA in 1970, it vested authority in the Attorney General, since delegated to DEA, to add, remove, or transfer substances among the schedules.

The up-to-date listing of schedules appears at 21 C.F.R. §§ 1308.11 through 1308.15. "Listed chemicals" are chemicals frequently used in the illicit manufacture of controlled substances. "List I" chemicals (mostly "precursor chemicals" scientifically) are "important" to the illicit manufacture of a controlled substance (see 21 U.S.C. § 802(34)); the up-to-date list appears at 21 C.F.R. § 1310.02(a). "List II" chemicals (scientifically, mostly agents, reagents, catalysts, and solvents), which are also used in unlawful drug production, appear at 21 C.F.R. § 1310.02(b). Listed chemicals are monitored through a domestic and international regulatory scheme that involves registration (for certain handlers of List I chemicals), record-keeping, and reporting (notably of unusual or suspicious proposed transactions). See 21 U.S.C. § 830.

### Methamphetamine and MDMA

DEA regulates methamphetamine and amphetamine as "Schedule II" controlled substances, the strictest level of control for any drug that has been accepted for medical use. Because of the strict accountability requirements under the regulatory scheme, very little of the methamphetamine or amphetamine abused in this country is diverted from legitimate channels; rather, these drugs are manufactured in clandestine laboratories here or abroad. The principal chemicals used to manufacture methamphetamine or amphetamine clandestinely—including ephedrine, pseudoephedrine, phenylpropanolamine, phenyl-2-propanone, hydriodic acid, and iodine—are regulated under domestic law as "List I" or "List II" chemicals, or as immediate precursors in Schedule II, and most are regulated by international law under the 1988 United Nations Convention Against

Illicit Traffic in Narcotic Drugs and Psychotropic Substances (hereafter referred to as "1988 UN Convention"). Listed chemicals are not as strictly regulated as controlled substances. Ephedrine and pseudoephedrine are the precursors of choice in most regions in the process to make methamphetamines because the chemical process is simple, a better yield is obtained and both are more widely available than phenylacetic acid and P-2-P. These chemicals are used extensively as decongestants in "over the counter" pharmaceutical preparations.

MDMA is a Schedule I controlled substance; its legitimate use is limited to approved medical and scientific research. During 2002, DEA scheduled two substances that had been marketed on the Internet as legal alternatives to MDMA—benzylpiperazine (BZP) and 2,5-dimethoxy-4-n-propylthiophenethylamine (2C-T-7). These two substances were recommended for Schedule I control and subsequently both were permanently controlled. In early 2003, DEA temporarily placed in Schedule I two other hallucinogenic/stimulant substances popular at raves and other social venues: alpha-methyltryptamine (AMT) and 5-methoxy-N, N-diisopropytryptamine (5-Meo-DIPT—known as "Foxy").

The precursor chemicals used to manufacture MDMA—safrole, isosafrole, 3,4-methylenedioxyphenyl-2-propanone (MDP-2-P) commonly known as PMK, and piperonal—are subject to domestic control as List I chemicals and international control under the 1988 UN Convention. PMK is the precursor favored by clandestine lab operators, who are concentrated in rural parts of the Netherlands. Produced only in China and India, there appears to be only limited legitimate commercial use for PMK, which has been seized in large quantities in Europe. Safrole, isosafrole, and piperonal have commercial uses in fragrances and flavorings.

Various essential oils, such as sassafras and camphor, contain large percentages of safrole. These oils are being found in illicit laboratories where they are used for the illicit manufacture of MDMA and its analogues. In many cases these oils are used directly in the manufacturing process, as it is not necessary to first extract or distill the safrole. More simply, it requires less work to use safrole than other precursor chemicals to manufacture MDMA. Vietnam appears to be one of the foremost illegal exporters of sassafras oil and safrole.

## Other Club Drugs

GHB is, for most purposes relevant to law enforcement, a Schedule I controlled substance, as a result of Congressional and regulatory action in 2000. See the "Hillory J. Farias and Samantha Reid Date-Rape Drug Prohibition Act of 2000" (P.L. 106-172), signed on February 18, 2000, and a DEA regulation following from that law, effective March 13, 2000, and published at 65 Fed. Reg. 13,235. The limited exception is that the manufacture, distribution, and dispensing of FDA-approved drug products containing GHB are subject to the less stringent physical security requirements applicable to Schedule III controlled substances. For example, storage in a steel cage, rather than a vault, is sufficient for Schedule III substances. See 21 C.F.R. § 1301.72.

As a result of the same law, on February 18, 2000, the precursor gamma butyrolactone—commonly known as GBL—became a List I chemical under the Controlled Substances Act (CSA). GBL is unique among precursors, however, in that it converts into GHB when ingested. For this reason, it is often trafficked not as a precursor chemical but as a drug of abuse in itself. In those cases, because of its similarity to GHB in structure and effect, GBL may be treated as a controlled substance analogue

under the CSA, subjecting traffickers to the penalties applicable to Schedule I controlled substances. See 21 U.S.C. §§ 813 and 802(32).

Ketamine was placed in Schedule III of the CSA on July 13, 1999. It is a legitimate pharmaceutical product for both human and veterinary use. Flunitrazepam (Rohypnol) is a Schedule IV controlled substance.

## Controlled Substance Analogues

A substance is a controlled substance analogue if (1) its chemical structure is substantially similar to that of a Schedule I or II controlled substance, (2) it has a stimulant, depressant, or hallucinogenic effect that is substantially similar to or greater than that of a Schedule I or II controlled substance, or (3) it is represented or intended to have a stimulant, depressant, or hallucinogenic effect that is substantially similar to or greater than that of a Schedule I or II controlled substance. See 21 U.S.C. § 802(32). Thus, whether GBL is treated as a List I chemical or a controlled substance analogue depends on the circumstances of its distribution. Another chemical, 1,4-butanediol, another analogue of GHB, also converts into GHB when in the body. Unlike GBL, however, it is not used to manufacture GHB and, therefore, is not regulated as a listed chemical. If it is intended for human consumption, then 1,4-butanediol, like GBL, may be treated as a controlled substance analogue.

The schedules of controlled substances discussed in this Action Plan are as follows:

| DRUG | SCHEDULE |
|---|---|
| Methamphetamine | II |
| Amphetamine | II |
| MDMA ("Ecstasy") | I |
| GHB (except FDA-approved Xyrem) | I |
| PCP | II |
| LSD | I |
| Ketamine | III |
| Hydrocodone (including Vicodin) | III for drug products, bulk is II |
| Oxycodone (including OxyContin) | II |
| Flunitrazepam (Rohypnol) | IV |

# Appendix E: Sentencing

## Methamphetamine and MDMA

Methamphetamine penalties are among the most severe provided for in the Controlled Substances Act. The law sets a dual / alternative formulation for determining quantity-based sentences for methamphetamine, in which "actual" or "pure" methamphetamine is distinguished from "a mixture or substance containing" methamphetamine. A 10:1 quantity ratio triggers both statutory and guidelines penalties for methamphetamine-mixture versus methamphetamine-actual. "Ice" methamphetamine, defined by the guidelines as d-methamphetamine hydrochloride of at least 80 percent purity, is sentenced like "actual" methamphetamine. Pursuant to the Methamphetamine Anti-Proliferation Act of 2000, the U.S. Sentencing Commission increased guidelines sentences for amphetamine to equal those for methamphetamine (although amphetamine still has no statutory minimum penalties). Additionally, the Commission increased sentences for key methamphetamine precursor chemicals.

The Commission has also increased its focus on MDMA sentences. As of May 2001, the Commission raised the guidelines for MDMA by lowering the quantities triggering the five- and ten-year guidelines sentences. As of November 2002 the Commission introduced a standard, assumed pill weight for MDMA of 250 mg/tablet, which clarified an issue that had produced inconsistent sentencing decisions among the courts.

Quantities triggering five- and ten-year sentences for methamphetamine, amphetamine, MDMA, and the major methamphetamine precursor chemicals under the Sentencing Guidelines are summarized in the following table.

| | 5 years (Level 26) | 10 Years (Level 32) |
|---|---|---|
| Methamphetamine, Amphetamine | 5 gm pure / 50 gm mixture | 50 gm pure / 500 gm mixture |
| Ice (80% pure d-meth) | 5 gm | 50 gm |
| MDMA (Ecstasy) | 200 gm (about 800 tablets) | 2 KG (about 8,000 tablets) |
| Pseudoephedrine, Ephedrine, PPA (Norephedrine) | 10 gm | 100 gm |

Also, pursuant to the 2000 enactment, the Sentencing Commission increased the base offense level for manufacturing amphetamine or methamphetamine to at least 27 (i.e., 70-87 months for offenders with no or minimal criminal histories) if the offense created a substantial risk of harm to human life or the environment (typical of most clandestine lab cases). The sentence is at least level

30 (i.e., 97-121 months) if the life in question was that of a minor or incompetent. The Act also criminalized the theft or interstate transport of anhydrous ammonia for the purpose of unlawful drug manufacture, as set forth at 21 U.S.C § 864, subject to a penalty of up to 10 years imprisonment and a fine. Effective November 1, 2001, the Sentencing Commission adopted guideline amendments that in practical effect, result in a level 14 sentence for this offense (i.e., 15-21 months).

## Other Club Drugs

Effective November 1, 2004, sentences for GHB trafficking will be significantly enhanced. At that time, the guideline will provide for sentences of approximately five years for trafficking in three gallons of GHB (or its analogues) and ten years for thirty gallons. These changes result from a Congressional directive in legislation enacted in April 2003. Before November 2004, the five- and ten-year guideline sentences are triggered by approximately 13.2 and 132 gallons, respectively.

These amendments follow other recent revisions to strengthen the guidelines with respect to GHB. Effective November 1, 2001, the Sentencing Commission eliminated the "cap" at offense level 20 for "Schedule I and II depressants," including GHB. The previous guideline resulted in a sentencing range of 33-41 months for first-time offenders trafficking in 40,000 or more "units" (20 liters, or approximately 5.3 gallons). Even with this amendment, until November 2004, it still takes 100,000 "units" of GHB (over 13 gallons) to trigger a level 26 (i.e., 63-78 months) sentence.

The sentencing guidelines will also be strengthened for serious offenses involving the GHB precursor GBL. As of November 2004, sentences of about five years will be triggered by 227 liters (instead of 1,000 kilograms) of GBL. Sentences for GBL will still be "capped" at level 30 (97-121 months for a first offense) at 2,271 liters or more. We understand that the Commission will soon consider additional revisions to lower the thresholds for GBL.

The guidelines will also include a sentencing enhancement for mass marketing controlled substances through the Internet. This increase will be especially useful in the "club drug" context, as these drugs, and their analogues, are often advertised and sold via the Internet.

The "Drug Induced Rape Prevention and Punishment Act of 1996" (P.L. 104-305) established special penalties of up to five years imprisonment and a fine for offenses involving 30 milligrams or more of flunitrazepam (a Schedule IV controlled substance) and up to 20 years imprisonment and a fine for offenses involving 1 gram or more. In response to sexual assaults committed with this drug, the bill also enacted 21 U.S.C. § 841(b)(7), which makes distribution of a controlled substance to a person without that person's knowledge, and with the intent to facilitate a crime of violence, including sexual assault, subject to up to 20 years imprisonment and a fine.

Ketamine, a Schedule III depressant, is subject to a maximum 5-year sentence for a first offense, but is not subject to a mandatory minimum penalty. The Sentencing Guidelines establish a maximum offense level of 20 (i.e., 33-41 months).

Effective November 2002, the U.S. Sentencing Commission amended the federal sentencing guideline applicable to violations of 21 U.S.C. § 856, the so-called "crack house" statute, which may be used against promoters and operators of rave type events designed or intended to facilitate drug trafficking.

The new guidelines raise the previous, inadequate base offense level from Level 16 (i.e., 21-27 months in criminal history category I) to Level 26 (i.e., 63-78 months in category I).

In April 2003, Congress approved amendments to broaden the scope of 21 U.S.C. § 856 (the "crack house" statute) to make the provision more clearly applicable to "raves" and similar events, where appropriate. The legislation also introduces stiff civil penalties to remove the profit motive from sponsorship of drug-oriented rave type events.

## Other Synthetic Drugs and Diverted Pharmaceuticals

Oxycodone, a Schedule II narcotic, is subject to a maximum 20-year sentence for a first offense, but is not subject to a mandatory minimum penalty. Effective November 5, 2003, the Sentencing Guidelines for oxycodone are based on the actual weight of the oxycodone in the tablet, not the total weight of the tablet; this differs from the treatment of most other controlled substances, including pharmaceuticals. At the equivalency set in the revised guidelines (1 gram of oxycodone = 6,700 grams of marijuana), a level 26 (roughly 5-year) sentence is reached at about 3,000 5-mg pills, 1,500 10-mg pills, 750 20-mg pills, and 375 40-mg pills. Level 32 (roughly 10-year) sentences apply for trafficking in 10 times those quantities, respectively. Before this recent change, the Sentencing Guidelines established base offense level 26 for trafficking in 200 grams of oxycodone and base offense level 32 for trafficking in 2,000 grams (2 kilograms). The weight of the pills, not just the active ingredient, determined the sentence. Use of the total pill weight led to incongruous results because the concentration of oxycodone in controlled release formulations such as OxyContin is much greater than that in standard, non-controlled release formulations (such as Percocet, Percodan, and Roxicet), which also contain other active ingredients like aspirin and acetaminophen. Concerns about disproportionate sentencing led the Sentencing Commission to examine and act upon this issue. DOJ provided input.

PCP shares with methamphetamine the unusual dual/alternative penalty structure, which distinguishes "pure" PCP from mixtures or substances containing it. Trafficking in 10 grams of PCP-actual or 100 grams of PCP-mixture triggers a 5-year mandatory minimum sentence. A 10-year mandatory sentence applies to trafficking in 100 grams of PCP-actual or 1 kilogram of PCP-mixture.

Statutory and guidelines penalties for LSD are not congruent. The statute sets five- and ten-year sentences at 1 and 10 grams, respectively, but includes the carrier medium, usually blotter paper, when determining the weight. See 21 U.S.C. §§ 841(b)(1)(A) and (B) and 960(b)(1) and (2) and *Neal v. United States*, 516 U.S. 284, 296 (1996). The Sentencing Guidelines exclude the carrier medium and treat each dose as 0.4 mg. Because the carrier medium is heavier than the actual LSD, and thus constitutes most of the weight, the interplay of these two provisions tends simply to result in imposition of the 5- or 10-year statutory minimum sentence.[88]

# Appendix F:

## Examples of Notable State Laws with Respect to Precursor Chemical Control

### Oklahoma

On 6 April 2004, Oklahoma enacted the nation's most stringent state methamphetamine precursor control law. Now, only licensed pharmacists or pharmacy technicians may sell products containing non-prescription pseudoephedrine. Products must be kept behind the pharmacy counter, or elsewhere if in a locked cabinet. The seller must obtain the purchaser's identification with date of birth; purchasers must be at least 18 years old, and they must sign a written log. Only nine grams may be sold to a person in 30 days. The pharmacist is responsible for keeping track of only his own store's sales until the state develops a real-time statewide electronic logbook Exceptions are provided for compounds in liquid, liquid capsule, or gel capsule form, and the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control may, by rule, exempt other products that its Director finds are not used in the illegal drug manufacture. See Okla. Stat. Title 63, §§ 2-212 and 2-332, as amended by H.B. No. 2176.

### Missouri

On 28 August 2003, Missouri enacted a law imposing additional restrictions on the sale of over-the counter-drugs containing the principal methamphetamine precursors. For products containing ephedrine, pseudoephedrine, or phenylpropanolamine as the sole active ingredient, stores may sell only two packages containing a total of six grams of precursor. Unless the retailer has an electronic anti-theft system, these products must be displayed either behind the checkout counter or within 10 feet of unobstructed view from an attended checkout counter. For "combination" products containing those precursors and other active medical ingredients, they may sell three packages containing no more than nine grams total. Knowing violations are subject to class A misdemeanor penalties; the store owner or operator may invoke in defense that an employee training program was in place. See Mo. Ann. Stat § 195.417 (2003).

# Notes

[1] Raves are all-night dance parties, usually advertised as "alcohol free" to allow for the admission of under-age children and young adults. Techno, industrial, trance, and other music genres are the focus of the rave experience. "Circuit parties" are multi-day gatherings of gay and bisexual men that occur each year at around the same time, in the same town or city and centered on one or more large, late-night dance events that often have a theme. Rave events attract from hundreds to thousands of participants, while circuit parties may attract as many as 20,000 men to a local community. Widespread and open drug consumption appears to be the norm at some of these events.

[2] GHB (gamma hydroxybutyric acid), under the trade name Xyrem, was approved in July 2002 by the Food and Drug Administration (FDA) for the treatment of cataplexy, a sudden loss of muscle tone associated with narcolepsy. The availability of small quantities of legally manufactured GHB has not changed the fact that the vast majority of abused GHB is of illicit origin.

[3] For more information, see the DEA FactSheet: http://www.usdoj.gov/dea/pubs/pressrel/methfact01.html

[4] The Drug Abuse Warning Network (DAWN) Report, prepared under the auspices of the Department of Health and Human Services, compiles information from a survey of data on patients seeking hospital emergency department treatment related to their use of illegal drugs or non-medical use of legal drugs. Since 1988, DAWN data has been collected from a representative sample of eligible hospitals—non-Federal, short-stay general hospitals with a 24-hour emergency department—located throughout the United States, but excluding Alaska and Hawaii. The data is used to estimate the total number of emergency room drug episodes and mentions of specific drugs in all such hospitals. The DAWN system also collects data on drug-related deaths from a nonrandom sample of medical examiners. DAWN emergency room mentions for all drugs have remained relatively stable from 1999 through the first half of 2002.

[5] SAMHSA Office of Applied Studies, DAWN 2001 data. Two out of three emergency room episodes involving ketamine involved alcohol or another controlled substance as well.

[6] The Monitoring the Future Study is conducted by the University of Michigan Institute for Social Research and funded by the National Institute on Drug Abuse (NIDA). The statistics reported here should be considered in the context of the overall U.S. drug use profile. The 2001 Household Survey estimates that the overall rate of "current illicit drug use" (defined in the survey as use within the past 30 days) increased slightly in 2001, but the rate had been stabilizing in previous years. The rate of current illicit drug use among youth age 12-17 (approximately 10.8 percent in 2001) is higher than the rate of use among the overall population age 12 and older (approximately 7.1 percent).

[7] SAMHSA Office of Applied Studies, DAWN 2002 data.

[8] The National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) program tracks trends in the prevalence and types of drug use among arrestees in urban areas. The program provides local area estimates of the rate of drug use among adult and juvenile arrestees based on voluntary and anonymous interviews and urine specimen collection undertaken within 48 hours of arrest. The program currently operates in 39 sites with data collection taking place for a period of time each calendar quarter. The ADAM program, however, does not report national estimates. Preliminary findings for 2001 are based on reports from 27 sites involving adult male arrestees. The reason for the regional variance in the data is unknown.

[9] Community Epidemiology Working Group, *Epidemiologic Trends in Drug Abuse: Advance Report*, June 2003, p. 10. Hawaii HIDTA 2003 Threat Assessment, pp. 23-24. According to the Treatment Episode Data Set (TEDS), admissions for methamphetamine abuse increased overall from 498 in 1993 to 1,548 in 2000. Nearly 36 percent of all adult arrestees tested positive for methamphetamine use. The methamphetamine-associated death toll rose from 27 deaths in 1998 to 54 in 2001.

[10] SAMHSA Office of Applied Studies, *The DAWN Report: Club Drugs, 2002 Update*, July 2004, p. 1-3.

[11] The Community Epidemiology Work Group (CEWG) of the National Institute of Drug Abuse collects and analyzes drug data from a number of quantitative and qualitative sources, including, among others, ADAM, DAWN, and DEA seizure, price, purity, prescription/distribution, and arrest data. The CEWG reports that in the 21 areas that comprise its surveillance network, MDMA is readily available at raves and other dance parties and nightclubs, and MDMA use is spreading beyond these locales into more casual social settings. Deaths linked to MDMA occur, but are unpredictable, and are not necessarily related to the dose (DAWN statistics reveal 27 deaths possibly linked between 1994 and 1998). The June 2002 CEWG report also notes that mentions of MDMA and other club drugs in mortality data, while climbing, remain relatively low.

[12] SAMHSA Office of Applied Studies, *The DAWN Report: Club Drugs, 2002 Update*, July 2004, p.1-3.

[13] 2002 Monitoring the Future study.

[14] SAMHSA Office of Applied Studies, *The DAWN Report: Club Drugs, 2002 Update*, July 2004, p. 1-3.

[15] 2002 Household Survey.

[16] SAMHSA Office of Applied Studies, *The DAWN Report: Oxycodone, Hydrocodone, and Polydrug Use, 2002*, July 2004, p. 1-3. The DAWN Report cautions that estimates for oxycodone mentions should not be attributed to any particular brand of analgesic containing oxycodone.

[17] SAMHSA Office of Applied Studies, DAWN 2002 data. Also see Community Epidemiology Working Group, *Epidemiologic Trends in Drug Abuse: Advance Report*, June 2003, p. 42, which states that PCP indicators increased in Los Angeles, Philadelphia, Phoenix, Washington, DC, and Texas, and remained steady in Chicago.

[18] 2000 Household Survey.

[19] Monitoring the Future surveys of LSD use began in 1991 for grades 8 and 10 and in 1975 for grade 12. The 2001 survey results were mixed, with past month use increasing among 12th graders from 1.6 percent to 2.3 percent, while past year use declined among 10th graders from 5.1 percent to 4.1 percent. As of 2001, an estimated 10.9 percent of 12th grade students reported use of LSD at some point in their lives.

[20] SAMHSA Office of Applied Studies, *The DAWN Report: Club Drugs, 2002 Update*, July 2004, p. 1-3.

[21] Unless otherwise noted, the source of the data in this section is DEA Headquarters.

[22] EPIC National Clandestine Laboratory Seizure System, 2003 data. Thanks to improved reporting, EPIC lab figures have become more comprehensive and reliable. The Bureau of Justice Assistance and the Community-Oriented Policing Services (COPS) program have agreed to require state and local governments to report lab seizures to EPIC as a condition of federal lab cleanup grants.

[23] EPIC National Clandestine Laboratory Seizure System, 2003 data.

[24] EPIC National Clandestine Laboratory Seizure System, 2003 data.

[25] Based upon the number of labs seized, a very rough estimate is that there are 10 times as many labs in operation as are ever seized. Base upon the amount of methamphetamine produced by these labs, officials estimate that up to 2,844,000 pounds of toxic by-products of methamphetamine production have been dumped in California.

[26] EPIC National Clandestine Laboratory Seizure System, Drug Endangered Children, 2003 data.

[27] The Netherlands and Belgium are conservatively estimated as being the source of roughly 70 percent of the MDMA consumed worldwide.

[28] EPIC National Clandestine Laboratory Seizure System, 2002 data. The number of labs seized in the United States during 1995-2002 is as follows:

| Year | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 thru Oct. 6 |
|---|---|---|---|---|---|---|---|---|---|---|
| # Labs | 3 | 5 | 4 | 4 | 13 | 8 | 11 | 10 | 10 | 13 |

[29] One cause for concern is the entry of Mexican, Dominican, Asian, and Colombian trafficking groups into the MDMA distribution network.

[30] Figure 18 reflects interagency data complied by EPIC, showing that approximately 1.5 million MDMA pills were seized in the U.S. arrival zone in 2003. This figure was down from approximately 3.6 million tablets in 2002, which was in turn less than the approximately 6.8 million tablets seized in 2001, the highest number ever; the figure for 2000 was about 5.8 million tablets. Domestic (non-arrival) seizure figures have shown a similar trend: approximately 3.5 million tablets in 2003, 8.3 million in 2002, 11 million in 2001, and 8.3 million in 2000.

[31] Customs 2001 seizure data.

[32] Community Epidemiology Working Group, EPIC, and DEA.

[33] Community Epidemiology Working Group, EPIC, and DEA.

[34] MDMA Trafficking in the United States, Epidemiologic Trends in Drug Abuse Advance Report, December 2001, Community Epidemiology Work Group. DEA uses various sources to assess the trafficking of MDMA in the United States. These included the United States Customs Service reports; the National Forensic Laboratory Information System (NFLIS); and the DEA Source Determination Program. DEA drug testing laboratories are located in seven CEWG areas: Miami, New York City, Washington, D.C., Chicago, Dallas, San Francisco, and San Diego. In addition, a special testing and research lab is located in Chantilly, Virginia.

[35] Rocky Mountain HIDTA 2002 Threat Assessment, p. 37. 2 labs were seized in Colorado Springs, and 1 lab was seized in Ft. Collins.

[36] Rocky Mountain HIDTA 2002 Threat Assessment, p. 37. This takedown was part of Operation Green Clover.

[37] An international ketamine smuggling organization was exporting thousands of vials at a time from Mexico on a frequent basis.

[38] Various sources within the Departments of Health and Human Services (HHS) and Justice provide data and analyses useful for detecting emerging drug trends that communities can target as part of their overall prevention efforts. Initiatives include State Incentive Grants for Community-Based Action distributed to 27 governors' offices and the mayor's office in the District of Columbia in support of planning for coordinated substance abuse prevention efforts.

[39] The National Institute on Drug Abuse (NIDA) conducts a comprehensive, multidisciplinary prevention research program examining the interaction of multiple factors that contribute to and protect against drug abuse. In 1997, based on more than 20 years of prevention research, NIDA identified fundamental principles of drug abuse prevention in the publication *Preventing Drug Use Among Children and Adolescents.* The publication also discusses community drug abuse risk assessment, prevention program implementation and evaluation, and scientific findings about the efficacy of several identified programs. This publication is currently being revised to account for new findings. NIDA's "InfoFacts" system and Research Report Series allow access to publications containing pertinent information with respect to prevention efforts targeting methamphetamine, the "club drugs," and OxyContin and other prescription drugs. Information is available on the Internet site www.clubdrugs.org. NIDA is now developing a Research Report publication that will focus on MDMA and possibly other synthetic drugs. Basic educational efforts include the teaching aid series "Mind Over Matter," a component of the "NIDA Goes to School" program that distributes information to schools and encourages students to learn about the effects of drugs on their bodies and brains. Research-based materials, such as a popular poster-magazine series, include a segment on methamphetamine, and NIDA is developing materials on MDMA. NIDA has completed a curriculum for high school students as well as curricula for second and third grade students; curricula for kindergarten, first grade, and fourth and fifth grade students are still under development. Furthermore, a teaching packet, "The Neurobiology of Ecstasy," now available on NIDA's Internet site, was developed for use by teachers and researchers primarily working with high school students. NIDA also recently set aside additional funding for the Prevention Research Initiative, which includes: (1) development of new approaches for prevention, building on scientific findings; and (2) enhancement of dissemination of effective prevention practices through multi-site studies in community settings.

[40] The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) has created a National Registry of Effective Prevention Programs (NREPP) to catalog programs found to be effective. Through this effort, CSAP has developed and implemented a comprehensive system to identify and disseminate scientifically proven model prevention programs to local communities. This effort directly supports the HHS State Incentive Grant program. Additionally, prevention research is funded through the Substance Abuse Prevention and Treatment Block Grant Program and the Programs of Regional and National Significance focus on more effectively delivering prevention services.

[41] In addition to urine-based tests conducted in specially inspected and certified laboratories, new federal regulations are nearing completion that would include alternative technologies allowing the testing of specimens such as hair, oral fluid, sweat, and allowing point of collection (onsite/immediate screening) tests. Further information can be found on the Internet at www.drugfreeworkplace.gov. The NLCP also collaborates with military, criminal justice, transportation, educational institution, clinical, and sports-related testing efforts nationally and internationally.

[42] The campaign involves $5 million in purchased messages targeting youth and adults and an additional $3.9 million in pro bono media-match messages targeting parents. In addition, ONDCP redesigned its newspaper and news-oriented magazine outreach efforts to better target parents and met with entertainment industry writers and executives in Los Angeles and in New York to discuss the dangers of synthetic drugs.

[43] Since 1998, DEA's Drug and Chemical Evaluation Section of the Office of Diversion Control, in conjunction with Demand Reduction and Training Coordinators from the 22 DEA field divisions, has provided scientific conferences on "club drugs" in over 70 communities across the U.S. that addressed and disseminated information to law enforcement, drug treatment pro-

fessionals, medical emergency technicians, physicians, and hospital staff on issues of health and safety regarding these drugs. It is estimated that over 10,000 state and local police officers have attended one of these conferences thus far.

[44] DEA is joining with anti-drug coalitions, the medical community, state legislators, community leaders, and ordinary citizens in "town hall" meetings that feature discussions between local residents and a panel of local and national experts. Meetings so far have taken place in San Diego, Kansas City, Miami, and New York, and more are planned. The campaign can be replicated and customized in communities across the nation. Additionally, "Integrated Drug Enforcement Assistance" (IDEA) is an integrated enforcement and community-based demand reduction program sponsored by DEA in six communities. The program features DEA enforcement activities followed by the implementation of a community developed strategy to prevent future illegal drug use. Additional pertinent DEA publications include *Get It Straight! A Prevention Book for Young Americans*. All publications are available on-line.

[45] The "early identification" of new illicitly used synthetic drugs, and the measurement and understanding of the true impact, require the development, validation, and dissemination of new drug detection tools and tests. The process includes a wide range of participants and resources from government, academia, instrument manufacturers, clinical and forensic pathologists, toxicologists, and their support laboratories. These groups network actively and recognize the need for new tests, but it remains a challenge to develop commercially available test products to specifically detect and measure the presence of some synthetic drugs.

[46] Much abuse trend information is collected by public health and law enforcement agencies. DEA is often able to undertake emergency regulatory action based on preliminary information about abuse and trafficking of non-controlled substances. For example, as noted in Appendix D of this Action Plan, from 2002 to the present, DEA has undertaken temporary, emergency scheduling of five club drugs, all of which had been marketed as legal alternatives to MDMA. As part of its function to monitor new and emerging drug problems, the Drug & Chemical Evaluation Section of DEA's Office of Diversion Control currently has a system which has identified specific drug problems well in advance of national crises as well. Likewise, institutionalized fora exist to review available data. An Interagency Committee on Drug Control (ICDC) meets monthly to discuss emerging drug problems and consider appropriate, multi-faceted responses. The ICDC involves the Office of National Drug Control Policy, the National Institute on Drug Abuse, the Food and Drug Administration, and the Drug Enforcement Administration. The Community Epidemiology Working Group meets twice a year to review current and emerging substance abuse data.

[47] These efforts may include, among other things, data from HHS Methamphetamine and Ecstasy infrastructure grant recipients and DOJ Weed and Seed sites, as well as data from NIDA/CEWG, DAWN, and DEA. The compilation and analyses can be used internally for policy and program development and could be made available in some form for community use from an existing Internet-accessed federal SAMHSA server using the Prevention Decision Support System query and needs assessment resources.

[48] SAMHSA's Substance Abuse Treatment Facility Locator, Treatment Improvement Exchange, and National Clearinghouse for Alcohol and Drug Information can be accessed via the internet at www.findtreatment.samhsa.gov, www.treatment.org, and www.health.org respectively.

[49] During the annual UN Commission on Narcotics and Drugs (CND) International Narcotics Control Board (INCB) meeting in Vienna, in March, 2001, the United States and the European Union (EU) passed a joint resolution on synthetic precursors:

- Recommending creation of an early warning system to identify and advise industry on new chemicals used in illicit synthetic drug manufacture.
- Urging countries to comprehensively test seized synthetic drugs and establish a network of collaborating laboratories to track new illicit drug manufacturing trends.
- Specifically targeting the precursor PMK, a key chemical in MDMA production with limited legitimate commercial use.

[50] 21 U.S.C. § 971.

[51] The procedures used by DEA to administer the "letter of no objection" system have been challenged, with partially adverse results, in the U.S. District Court for the District of Columbia. PDK Labs Inc. v. Ashcroft, Civil Action Nos. 00-2894 and 00-2899 (HHK). PDK Labs Inc. is a manufacturer of drug products containing precursor chemicals, but is not registered to import such chemicals. PDK challenged DEA's denial of its right to request an administrative hearing after DEA failed to grant a letter of no objection to the firm importing chemicals for sale to PDK.

[52] Title VI, Subtitle A of Pub. L. 100-690 (part of the "Anti-Drug Abuse Act of 1988"), passed November 18, 1988.

[53] Title XXIII (Sec. 2301) of Pub. L. 101-647 ("Crime Control Act of 1990), November 21, 1990.

[54] Pub. L. 103-220, effective April 16, 1994.

[55] Pub. L. 104-237, signed October 3, 1996. DEA has finalized implementing regulations, with a transaction threshold of 0.4 kilograms (about 1 pound). In order to ensure that the federal government itself does not become a source for diverted chemical materials, the DEA, pursuant to 21 U.S.C. § 890 and procedures in recently published proposed regulations, monitors sales of crude iodine from the chemical stockpiles maintained by the Department of Defense. With respect to each known potential bidder, DEA certifies whether there is reasonable cause to believe that a sale would result in the illegal manufacture of a controlled substance. To make this determination, DEA examines the prospective bidder's and end-user's past experience in maintaining effective controls against diversion and other relevant factors. The system works satisfactorily, although it is difficult for DEA to generate the necessary certification correspondence within the 15 day bid "window" when a new firm appears as a bidder. Overall, diversion from this stockpile is unlikely because of the close government scrutiny, the very large volumes involved (5,000 pounds is the smallest quantity purchased under the program so far), the transportation logistics, and the extensive processing required to make the crude form of extracted iodine commercially useable.

[56] United States v. Lopez, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring), cited and quoted in Grutter v. Bollinger, 539 U.S. 306, 342 (2003).

[57] There have been reports of more frequent theft of anhydrous ammonia, a farm fertilizer used to manufacture methamphetamine. Theft of anhydrous ammonia is a federal crime, see 21 U.S.C. 864. Some states, such as North Dakota, have taken actions to improve security at ammonia distribution centers and to encourage farmers to buy locks for their anhydrous ammonia tanks. Some states have criminalized or enhanced penalties for the theft of anhydrous ammonia. Further efforts, such as federal assistance to develop a "best practices" manual, may be warranted.

[58] See 21 C.FR 1310.12 and 1310.13, as published at 68 Fed. Reg. 23195 (May 1, 2003).

[59] In addition to the above figures, 20,000 kilograms of ma huang, which contains ephedra, were voluntarily withdrawn by an importer in May 2003, due to new FDA action which effectively banned the marketing of ma huang in products marketed as dietary supplements.

[60] A public-private Suspicious Orders Task Force was established as a result of Sec. 504 of the Comprehensive Methamphetamine Control Act of 1996. The group consisted of federal and state regulators and law enforcement officials and the regulated business community; it met five times and, in a report to the Attorney General dated February 1999, agreed to several voluntary measures that, if widely implemented, will assist both industry and law enforcement. The Suspicious Orders Task Force identified indicators of suspicious transactions, recommended that manufacturers of retail over-the-counter drug products containing methamphetamine precursors limit package sizes and use only "blister" packaging, and recommended that all retail sales of elemental iodine and red phosphorous be reported to DEA. Many segments of industry have implemented these recommendations.

[61] Pfizer Pharmaceutical invested $12 million over five years into the development of a new technology which would make it impossible for methamphetamine traffickers to use Sudafed and related products for illicit purposes. While initial attempts proved unsuccessful, research continues.

[62] The final regulations were published in the Canada Gazette Part II, Vol. 136, No. 21 on October 9, 2002. A 1996 law, the "Controlled Drugs and Substances Act," was unable to stem the chemical flow until these implementing regulations were promulgated.

[63] The operations undertaken so far have been, in order, "Purple" for the cocaine oxidizing agent potassium permanganate, "Topaz" for the heroin chemical acetic anhydride, and "Prism" for the precursors to amphetamine-type stimulants.

[64] The U.S. position is that such pharmaceutical preparations should be controlled pursuant to Article 12(14) of the 1988 UN Convention.

[65] Under the Methamphetamine Anti-Proliferation Act of 2000 (MAPA), DEA was directed to prepare a report to Congress on the blister pack exemption. DEA forwarded a report to Congress in November of 2001 recommending the removal of this exemption and the imposition of a strict 9 gram threshold, the limit allowed by Congress for non-blister pack product, and the current threshold for non-blister pack pseudoephedrine products. See Sec. 3642 of the Methamphetamine Anti-Proliferation Act of 2000, set forth at 21 U.S.C. § 802 (note), for more details. In October 2003, Sen. Feinstein introduced a bill (S.1784) proposing the removal of this exemption.

[66] See 21 U.S.C. § 971.

[67] Although DEA regulates imports of listed chemicals through a pre-notification/verification system and "letters of no objection" to governments in key chemical source countries, it effectively loses oversight once a shipment enters the United States. If the importer's sale to the declared customer is not consummated, the chemicals may be sold on the "spot market" without DEA oversight, which in effect circumvents the legal controls on chemical imports.

[68] See for example 21 U.S.C. 952 (import controls), 823 (registration requirements), and 826 (production quotas). For technical reasons, it is impractical under the current laws to designate bulk ephedrine and pseudoephedrine as "immediate precursors" of methamphetamine. See 21 U.S.C. 802(23), but see also 811(g).

[69] Because pharmacies are specifically exempt from registration to handle List I chemicals, by virtue of their registration to handle controlled substances (they would also be exempt as retail outlets under a separate provision of the DEA regulations), they do not receive pre-registration site visits by DEA and are not systematically made aware of the chemical diversion problem. Cases involving large-scale diversion from pharmacies have been reported nationwide and, in many cases, in regions not associated with methamphetamine production.

[70] The continued proliferation of thousands of small clandestine methamphetamine labs throughout much of the country is fueled by retail-level theft and "smurfing" (the purchase of small amounts of product at several locations to avoid attention). To curb these practices, it will be necessary to further control access to the most popular precursor in the most widely used form—pseudoephedrine in over-the-counter medications—without precluding access by law-abiding consumers. Some states have imposed stricter controls than apply under federal law. For example, they set purchasing limits on all pseudoephedrine and ephedrine products, regardless of the form of packaging. Several counties and municipalities in Missouri require the placement of these products behind the store counter, much like cigarettes.

[71] Shortly after his confirmation, former DEA Administrator Asa Hutchinson made methamphetamine one of five priority areas. In Spring 2002, he launched a tour with the theme "Meth in America, Not in Our Town," a nationwide campaign to raise awareness of the growing methamphetamine problem.

[72] The NMCI has created a secure, internal web site where law enforcement officials share ideas and information.

[73] The task force includes representatives from DEA, FBI, ICE, DCIS, EPA, US Attorneys' Offices, the California Department of Justice, the Kentucky State Police, the Oregon State Police, the Rocky Mountain HIDTA, the Arizona Attorney General's Office, the California Department of Toxic Substance Control, the Phoenix Police Department, the Mesa, Arizona Police Department, and the Arizona Department of Public Safety.

[74] The funds are provided to DEA through the Community-Oriented Policing Services (COPS) program.

[75] Two DEA components provide training on Internet-based investigations.

[76] Persons tracing their national and ethnic roots to the Middle East have been disproportionately represented among the ranks of "rogue" chemical company executives, brokers, and smugglers of illicit pseudoephedrine from Canada to the United States.

[77] Median sentences in 2000 and 2001 were 30 months.

[78] Specifically, two large-scale traffickers were extradited from Israel on charges in Miami in July 2002 for conspiracy to import MDMA into the U.S. (the first extradition of any Israeli citizen to the U.S. for a drug crime); three Israelis, who were part of a sophisticated drug trafficking organization based in Israel, were arrested after an international controlled delivery of 1.4 million Ecstasy pills hidden in three diamond polishing tables; and Israeli citizen Oded Tuito, a designated "kingpin" under the Foreign Narcotics Kingpin Designation Act, was indicted and extradited from Spain to face charges in the Eastern District of New York (Brooklyn) stemming from his leadership of the world's largest MDMA smuggling ring.

[79] 21 U.S.C. 856.

[80] Labs that produce less than two ounces of methamphetamine per batch are considered small labs. See USSG § 2D1.1(c)(6), which responds to Sec. 3612 of MAPA. Career offender enhancements may also be available in these cases. See USSG §4B1.1.

[81] In 2000, only 31 federal methamphetamine defendants received this adjustment under Sentencing Guideline USSG § 2D1.1(b)(5). While not all 3,358 methamphetamine offenders were prosecuted for offenses related to manufacturing—as opposed to importation or distribution—the number of labs seized indicates that many were charged with manufacturing methamphetamine.

[82] These "fake" and "knock off" products add to the existing uncertainty and danger of the drug market, and in particular the club drug scene.

[83] Some of the approaches suggested in this outline for faster and more comprehensive data gathering and dissemination could require additional resources. As appropriate, options for additional funding should be considered.

[84] This data can be complemented by review of "Microgram," a publication compiled by the DEA Office of Forensic Sciences that tracks unusual drug seizures and means of concealment.

[85] Small cities and towns and rural areas must somehow be included—this will help avoid missing the "next" OxyContin or methamphetamine problem. It is acknowledged that it will be a challenge to select "representative" or "bellwether" towns.

[86] The new equivalencies for MDMA and related substances were first set by emergency amendments to USSG § 2D1.1 (Amendment 609, effective May 1, 2001) and were repromulgated and made permanent by Amendment 621. See U.S. Sentencing Guidelines Manual, supp. to app. C. (2001).

[87] USSG § 2D1.1, Amendment 640 (2001).

[88] For consistency and simplicity, references throughout this Action Plan are to Sentencing Guidelines ranges for "criminal history category I." Generally, offenders in this category have never been incarcerated or have been imprisoned on only one occasion for less than 60 days. Chapter 4 of the U.S. Sentencing Guidelines sets forth a point system of factors for assessing a defendant's criminal history. The higher the criminal history category, the longer the sentence.

[89] The Commission's proposed changes, which will go into effect unless Congress revises them, were published at 69 Fed. Reg. 28994 (May 19, 2004).

[90] This Action Plan includes only limited recommendations for changes to the federal sentencing guidelines. Rather than setting forth extensive proposals at this time, DOJ components will work to assure that, if necessary, legislative and guidelines changes occur so that sentences for particular offenses more appropriately reflect the harm suffered.

[91] U.S. Sentencing Guidelines Manual, supp. to app. C. (2001), Amendment 640.

[92] Section 608 of Pub. L. 108-21 (passed as S. 151), signed April 30, 2003 (the "PROTECT Act").

[93] It should be noted that affirmative civil litigation seeking civil penalties and injunctions under the Controlled Substances Act against persons and firms that violate the chemical control system has increased in recent years. A small, informal cadre of federal affirmative civil enforcement litigators has developed— some focusing on chemical importers and over-the-counter drug manufacturers in judicial districts far from areas of methamphetamine production

The Oregonian

SANDRA MIMS ROWE
EDITOR

1320 S.W. BROADWAY
PORTLAND, OREGON 97201-3499
PHONE: 503-221-8400
FAX: 503-294-4175

November 1, 2004

Enclosed is The Oregonian's ground-breaking series, "Unnecessary Epidemic." The series delivers something you have never read before: a potential road map for hobbling the illegal trade in methamphetamine.

Sixteen states now treat more people for addiction to this powerful stimulant than for cocaine or heroin. Meth's influence has crept steadily eastward, and recent data show the drug is rapidly attracting new users in Illinois, Kentucky and Georgia. An estimated 1.3 million Americans, many of them in small towns and rural counties, used meth in 2003.

Contrary to popular perception, an estimated 80 percent of meth in America is produced by Mexican drug cartels. These cartels have flooded the market by procuring massive quantities of two chemicals - ephedrine and pseudoephedrine - and converting them to meth in massive California "superlabs."

The Oregonian's investigation reveals that the cartels are surprisingly vulnerable to government pressure. Twice in the 1990s, federal drug agents choked off the flow of cough and cold medicine to the black market, rolling back the abuse of meth and saving lives. Rarely has the U.S. government had such a measurable impact on drug abuse. "Unnecessary Epidemic" shows that these overlooked successes can be repeated.

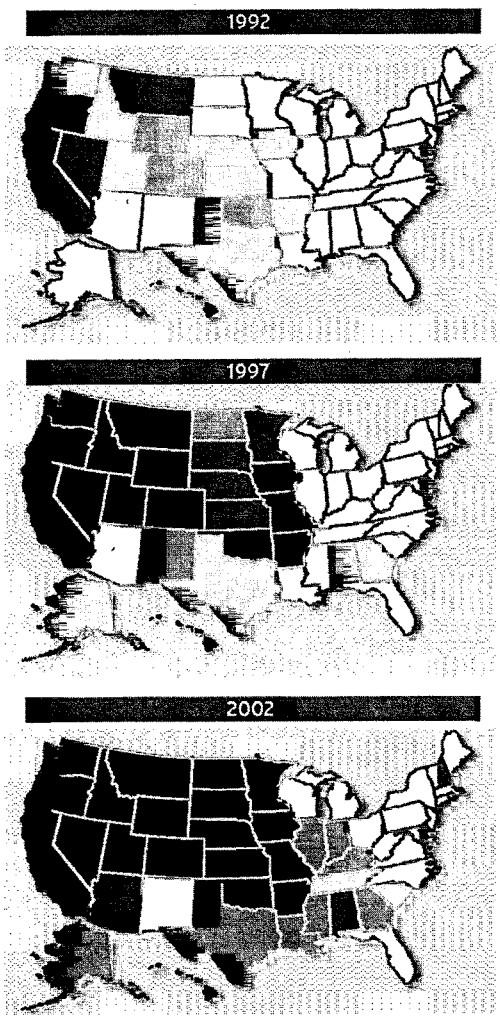
I have enclosed a brief summary of the newspaper's findings, which were based on two years of original reporting in the United States, Canada and India. Please feel free to share this summary with others who may be pursuing solutions to the meth epidemic. For more reprints of the series, please contact reporter Steve Suo at 503-221-8288.

I look forward to hearing your thoughts on this important series.

Sincerely,

Sandra Mims Rowe

Sandra Mims Rowe
Editor




**THE SPREAD OF METH**

REHAB ADMISSIONS FOR METH PER 100,000 RESIDENTS

0 to 5 | 5 to 10 | 10 to 20 | 20 to 40 | 40 or more

Methamphetamine abuse, as measured by the number of people entering rehab centers, spread eastward during the past decade while intensifying in the West. The maps below show the number of people treated for meth abuse per 100,000 residents age 12 and older.

**Summary of "Unnecessary Epidemic"**

In its five-part series, "Unnecessary Epidemic," The Oregonian newspaper shows how the federal government can stop the nation's devastating methamphetamine problem: by choking off the black market in chemicals used to make the potent stimulant.

The series – based on an original analysis of emergency room admissions, arrests, treatment caseloads, property crimes and illicit drug prices – shows that the meth trade is surprisingly vulnerable to government pressure.

The newspaper identified two periods in the 1990s when U.S. authorities succeeded in clamping down on the flow of legal chemicals used in the meth trade. Each time, meth production slowed and abuse of the drug subsided. The Oregonian found that these overlooked successes can be repeated, at relatively little cost to taxpayers or consumers, if policymakers seize upon this unique opportunity in the war on drugs.

Debate over how best to battle meth has been clouded by misperceptions. Television news highlights the role of local methamphetamine labs, suggesting that meth abuse has spread because the drug is easily brewed at home. Such home labs are dangerous and costly to clean up. Yet they are a minor factor in the U.S. meth supply. They have little to do with why meth is cheap and plentiful.

According to the U.S. Drug Enforcement Administration, Mexican drug cartels operating in California make 80 percent of the meth consumed in the United States. These cartels must procure hundreds of tons of two legal chemicals: ephedrine and pseudoephedrine, common ingredients in cough and cold medicine. This is meth's Achilles' heel.

There are only nine major producers of ephedrine and pseudoephedrine in the world. And, unlike farmers who raise coca and opium poppies, chemical companies have a stake in keeping their products off the black market. Help these companies to do so, and production by the meth cartels withers. The series highlights several possible approaches:

- **Science.** Congress could finance research into cold medicines that will not make methamphetamine. Pfizer, maker of Sudafed, holds a patent for such a medicine, and overseas chemical producers say they can manufacture the new ingredient. However, Pfizer hasn't brought the product to market because of the lengthy clinical trials needed. Congress has offered no incentives for further research.

- **Diplomacy.** Only four countries - India, China, Germany and the Czech Republic - manufacture ephedrine and pseudoephedrine. The DEA or, alternatively, the Food and Drug Administration could easily track every shipment from the factory floor. In fact, company executives and local drug officials in India were glad to share such information with The Oregonian, but the DEA has never asked for it.

- **Tighter law enforcement.** The DEA already has regulatory authority over the trade in ephedrine and pseudoephedrine. The agency approves import permits or and issues licenses to wholesale distributors. But DEA spends only $20 million annually for this purpose. A registered distributor of pseudoephedrine faces only a 1 in 7 chance of being audited by DEA each year. Some have remained in business despite 20, 30 and 40 warnings that their products have been found in meth labs.

The Oregonian

# UNNECESSARY EPIDEMIC

**The siren of meth fuels crime and ravages communities across the West, but an analysis by The Oregonian shows sustained pressure by government could stop the . . .**

## Unnecessary epidemic

Sunday, October 03, 2004

STEVE SUO

A decade ago, federal authorities choked off the supply of chemicals needed to make methamphetamine, a cheap, potent stimulant that was devastating the West.

The drug grew scarce, and rehab centers saw fewer meth patients. Emergency rooms reported fewer meth overdoses. Fewer people were arrested for possessing the drug. Identity theft and car theft -- crimes typically committed by meth addicts -- fell in several Western cities.

Federal agents had vastly improved the quality of life, but they didn't know it.

Within a year, the drug cartels that make most of the nation's methamphetamine found new ways to obtain their ingredients, taking advantage of a loophole left open by Congress. As a result, meth use rebounded, and the epidemic spread eastward. Today, an estimated 1.3 million Americans smoke, snort or inject the drug.

An investigation by The Oregonian shows that Congress and federal authorities could have contained the methamphetamine epidemic, and still can.

The investigation establishes for the first time that methamphetamine traffickers are uniquely vulnerable to government pressure.

Methamphetamine differs from heroin and cocaine, which are distilled from plants grown across vast stretches of South America and Asia. Drug dealers create meth from ephedrine or pseudoephedrine, chemicals used to make cough and cold remedies such as Sudafed. Only nine factories manufacture the bulk of the world's supply.

Deprive traffickers of ephedrine and pseudoephedrine, and the meth trade withers.

Peter Reuter, a leading drug expert and longtime skeptic of the government's ability to disrupt the drug trade, said The Oregonian's findings were startling. Reuter called them the first convincing evidence that government and law enforcement agencies could substantially reduce meth addiction.

The research, he said, shows that tightening control over the supply of meth chemicals would make "a significant difference to the criminal interests" while modestly inconveniencing consumers.

"I have been asked in the course of the presidential campaign, 'Why doesn't anyone talk about drugs?' " said Reuter, a University of Maryland professor who served on the Clinton administration's meth task force.

The answer, Reuter said, is that no candidate has a plausible approach.

"Here, you actually do have a better idea."

The Oregonian found striking correlations between government actions and meth abuse. In two periods -- 1995-96 and 1998-99 -- federal authorities interrupted the flow of chemicals to drug cartels. Each time, crime and addiction fell in tandem as the price of the drug rose.

The Oregonian discovered these previously overlooked successes by examining millions of reports on arrests, emergency room admissions, drug treatment, and the price and potency of meth seized by drug agents.

Until now, federal officials were unaware of the extent to which their policies succeeded.

The U.S. Drug Enforcement Administration began calling for much tighter control over ephedrine and pseudoephedrine nearly two decades ago.

But lawmakers were reluctant to interfere with the legitimate trade and said the DEA had no proof the approach would work. The pharmaceutical industry lobbied its allies on Capitol Hill and in the White House to delay or soften legislation that would have harmed the $3 billion market in popular cold products.

When Congress finally gave the DEA broad authority over the trade in pseudoephedrine in 1996, the agency did not take full advantage of the powers it had sought.

The agency allowed companies it licensed to continue selling cold medicine, even after 20, 30, 40 written warnings that their products were found in meth labs.

The DEA said it has tightened its registration program since 2000, when a number of officially approved dealers were charged with supplying pseudoephedrine to meth traffickers. In a written statement, the agency said it had "always considered" the control of meth chemicals a "high priority."

Meth abuse is particularly widespread in Oregon, which treats more people for meth addiction per capita than any other state in the country.

The drug, sold in powder or rock form, delivers an intense rush. A few hits cost just $25. Heavy users stay awake for days, growing paranoid and aggressive before crashing into sleep.

Gov. Ted Kulongoski now calls meth the most pressing crime issue facing the state. Police in Portland and surrounding suburbs say that meth users are responsible for thousands of identity thefts each year.

In rural communities such as Coos County on the Oregon coast, social workers say meth abuse plays a role in most cases of child abuse and neglect.

The story is repeated in communities across much of the country. More people are now in rehab for meth addiction than for cocaine or heroin in 16 states. And recent treatment data show the drug is rapidly drawing new users in places such as Illinois, Kentucky, Alabama and Georgia.

The problem has been slow to reach the attention of national policymakers, in part because the threat remains distant from the nation's major East Coast cities.

Authorities in Portland, Spokane, San Diego and Phoenix report that 25 percent to 38 percent of men arrested for any crime have methamphetamine in their bloodstream. The comparable rates in New York and Washington, D.C., are less than 1 percent.

Nancy Bukar, a lobbyist for the Consumer Healthcare Products Association, argues that the regional nature of the problem weighs against further restrictions on pseudoephedrine products.

"You've got to strike a balance here," said Bukar, whose group represents pharmaceutical companies. "Yes, they're being used in an illegitimate fashion by some people, but the major majority of people are using it for colds and to unstuff noses."

Over the past decade, meth traffickers have displayed an uncanny ability to outwit regulators and obtain their raw materials. But former DEA officials say the government has failed to make a concerted effort to deprive traffickers of two chemicals produced in only four countries.

The Oregonian's study shows that a national strategy to halt the flow of meth chemicals could be accomplished with little effect on consumers and relatively low cost to taxpayers.

U.S. diplomats could work with officials in India, China, the Czech Republic and Germany to more closely track every sale of pseudoephedrine from the few factories that produce it. Right now, DEA officials review only exports from those countries to the United States and Mexico.

U.S. diplomats could work with officials in India, China, the Czech Republic and Germany to more closely track every sale of pseudoephedrine from the few factories that produce it. Right now, DEA officials review only exports from those countries to the United States and Mexico.

That approach failed to immediately detect a huge smuggling route through Canada that opened in the late 1990s.

The National Institute on Drug Abuse, which spends $1 billion a year on addiction research, could dedicate some money to developing an effective decongestant that cannot be converted into meth.

Pfizer, one of the leading sellers of cold medicine in the United States, holds the patent to such a medicine. It has never been brought to market, Pfizer says, because it was not enough of an improvement as a cold medicine to make it commercially viable.

The government could provide incentives for drug companies to create such a product, just as it already subsidizes research on unprofitable "orphan drugs" that promise cures for rare diseases.

Finally, the DEA could take a more aggressive approach to overseeing the trade in the two key chemicals used to make meth. The agency spends $700 million annually eradicating coca plants in South America. It devotes only $20 million to tracking the flow of pseudoephedrine and ephedrine -- the same amount the city of Portland spends annually on its motor pool.

John Coleman, DEA's former chief of operations, said the agency "could do a lot of phenomenal things" if it put more money into regulating drug chemicals.

"We're keeping the accomplishments low by keeping the staffing low," said Coleman, who also served as head of the DEA's offices in Boston and Newark, N.J.

"It's not very hard, really," he said. "It's just like shooting fish in a barrel. But you have to have the bodies."

**Trend across states**

The Oregonian set out to understand what caused the explosive growth in meth abuse during the 1990s.

First, the newspaper analyzed the records of 282,000 people entering rehabilitation programs for methamphetamine abuse in Oregon, Washington and California from 1992 to 2000. Their names were obscured to protect their privacy.

Researchers who study drug abuse have used treatment statistics as a barometer of the number of addicts. Just as population growth can be seen in clogged freeways, a rise in patients reporting to rehab centers is a sign that the drug problem is worsening.

The rise and fall of patients in rehab is an imperfect measure that could also reflect changes in availability of treatment and other factors. For this reason, The Oregonian examined treatment data from multiple states in combination with statistics on crime, emergency room admissions and arrests.

During the 1990s, the number of patients in Oregon, Washington and California admitted for meth abuse soared. But during the two periods in which federal authorities restricted access to the chemicals needed to make meth -- 1995-96 and 1998-99 -- clinics saw their meth caseloads sharply decline.

In those years, the numbers of patients diminished in Oregon, Washington and California, three states with different approaches to rehabilitation. That pattern was seen among people who voluntarily entered treatment and those ordered to do so by courts and child welfare agencies.

The Oregonian compared these treatment statistics with the number of trauma and overdose patients admitted to emergency rooms with meth in their blood. The patterns were identical.

The newspaper next examined arrests for methamphetamine possession in the same period. No statewide data were available for Oregon and Washington, but in California the numbers rose steadily except in 1995-96 and 1998-99.

Finally, the analysis turned to data on two crimes most commonly associated with meth users in Oregon: forgery and fraud. Data statewide, as well as for Portland and Salem, once again showed improvements in 1995-96 and 1998-99.

Police in Spokane; Salem; Sacramento; Kennewick, Wash.; and Phoenix reported the number of vehicles stolen monthly dipped or leveled off in 1995-96 and again in 1998-99 -- the same periods when other indicators of meth use were falling. Annual FBI data showed similar declines in rural counties of Arizona, New Mexico, California, Oregon, Idaho and Washington.

The similarity among these multiple measures of meth abuse was striking. The numbers of meth rehab patients, overdoses, arrests and property crimes moved in unison, matching one another in many cases across states down to the month.

Taken together, the data The Oregonian examined show there was good news hidden within the deluge of meth-related crime stories of the past decade.

But what caused such simultaneous, dramatic changes in the drug habits of individuals living thousands of miles apart?

The answer lay in the supply of the drug itself -- an aspect of the meth trade that turned out to be highly susceptible to government intervention.

**Myths of meth**

The most common belief about meth is that its use has grown rapidly because anyone can make it. Television news features colorful scenes of houses ablaze after volatile meth chemicals used by home cookers ignite.

The reality: Despite the existence of thousands of such home labs across the country, federal drug agents say local users make very little of the meth consumed in the United States.

From Oregon to Iowa, the DEA estimates that four out of every five hits of meth are cooked by Mexican organized crime syndicates operating in California, where they began making the drug on a grand scale a decade ago.

Their ability to produce plentiful, highly pure meth propelled the drug's popularity.

In the 1970s, meth was a minor West Coast fad. California motorcycle gangs discovered the powerful stimulant first synthesized by a Japanese chemist in 1919.

In 1980, the bikers' main ingredient, phenyl-2-propanone, came under federal control. So, underground cooks turned to ephedrine, a mild stimulant whose main legal use was as an asthma medication. To their surprise, ephedrine made meth twice as potent.

Prosecutors say a small-time Mexican cocaine runner named Jesus Amezcua Contreras and his brother, Luis, saw the commercial possibilities.

"This was not some Laurel and Hardy, dumb bunch of bikers that made meth in their back yards," said Larry Cho, a federal prosecutor who obtained a 1994 indictment against Luis Amezcua in Orange County, Calif. "Those guys were starting to industrialize the methamphetamine process. They made it into a business."

The key to their success, DEA officials say, was a massive and steady supply of ephedrine.

By 1989, the U.S. government had regulated sales of ephedrine powder, but the law exempted sellers of ephedrine pills -- because the product was a legitimate asthma medication.

Some meth cooks began to tap a gray market that hawked these products in adult magazines as "energy boosters."

But the Amezcua brothers went to the source, prosecutors say, arranging directly or through middlemen to purchase bulk ephedrine powder from manufacturers in Germany, the Czech Republic, India and China. A federal indictment says the Amezcuas and their scouts roamed Europe and Asia, placing orders by the ton.

By 1992, the brothers were shipping unprecedented quantities of ephedrine into Mexico and on through Tijuana to Southern and Central California, according to court documents. There, the Amezcuas and other cartels that followed found plenty of migrant labor and mile after mile of open space in which to hide a revolutionary process for making meth.

Drug agents from San Diego to Sacramento began discovering labs that cooked meth in a flask the size of a beach ball, big enough to hold 11 two-liter bottles of soda. As many as 12 of these giant globes were strung together, for a capacity of 144 pounds of pure meth every 48 hours.

Cut to street purity, that amount of meth would equal 1 million doses -- enough to keep tens of thousands of heavy users high for days. By contrast, home-based labs produce about one ounce of meth at a time, enough for 280 doses.

Seemingly overnight, cookie-cutter copies of the mammoth labs were everywhere. The operators were migrant workers, paid and trained by mysterious benefactors to keep the labs running and their mouths shut.

The product entered existing Mexican distribution channels for heroin and cocaine that stretched as far as North Carolina.

As meth became more abundant, dealers had less need to dilute it. The drug's purity rose.

Purer drugs are more habit-forming, studies have shown. Primates and rats, trained to press a lever that releases a shot of drugs, learn the trick faster when the initial dosage is strong.

Purer drugs also reduce the cost of getting high. A $25 bag of meth lasts longer. Numerous studies in both humans and animals show that when the "cost" goes

down, users get high more often -- just as motorists choose to drive more when gasoline is cheap.

That is what happened with meth from 1991 to 1994.

The average purity of meth doubled nationally in those years, reaching more than 70 percent, according to a RAND Corp. analysis of DEA data.

The highly potent meth hit the street simultaneously in nearly every Western state, The Oregonian's analysis shows. Soon after, the numbers of people entering rehab for methamphetamine addiction, arrested for meth possession and suffering overdoses began to rise.

Drug cartels had created a national habit by making meth plentiful and pure. But the secret to their success -- the ephedrine pipeline -- was about to be exposed.

**The perfect storm**

One day in March 1994, a shipping agent in Frankfurt, Germany, made a mundane but fateful decision that would bring chaos to the market that the Amezcua brothers had built.

A customer with a shipment of 120 cardboard barrels bound for Mexico City had left explicit instructions to steer the load clear of U.S. ports. But the flight to Mexico City was overbooked and beyond its allowable cargo weight. Contrary to the shipper's wishes, the agent sent the load on a Lufthansa flight that landed in Dallas.

There, the shipment immediately raised suspicions. U.S. Customs agents on the tarmac noticed that the labels had been altered. They pried open the barrel lids and found 3.4 metric tons of pure ephedrine powder, enough to cook up more than 41 million doses of methamphetamine.

It was a lucky break. For the first time, federal investigators had evidence they could use to trace precisely who was supplying ephedrine to the Amezcuas.

Four months after the first multiton seizure, customs agents in Dallas seized another 2.4 tons of ephedrine. In October, Dutch authorities at Amsterdam's Schiphol Airport stopped a 6.9-ton shipment of ephedrine that was bound for Guadalajara.

Terry Woodworth, who recently retired as the DEA's deputy director of diversion control, called the string of discoveries "an eye-opener."

"We were, to be candid, not as aware of that situation as we should have been until the Dallas-Fort Worth seizures," Woodworth said.

DEA officials flew to a meeting of the International Narcotics Control Board in Vienna to confront their counterparts from the countries that had unwittingly helped the Amezcuas obtain their ephedrine. Within months, the manufacturing countries and nations that were stopover points enacted stringent export restrictions.

In the United States, meanwhile, Congress had moved to choke off access to ephedrine pills, which had been protected from regulation and were being found by the millions in meth labs. A new law, requiring sellers of ephedrine pills to register with the government, was scheduled to take full effect in 1995. Many shady operators were scared away.

As a final blow, an IRS investigation led to a mail-order pill maker suspected of providing tons of ephedrine to the meth market in pill form. DEA agents shut down the Pennsylvania company in May 1995.

DEA officials say that in just 18 months, they and their foreign counterparts blocked or seized an estimated 170 to 200 tons of ephedrine. It was a sixth of the world's entire annual production.

"The hose was clamped," said Gene Haislip, former head of the DEA office that tracks chemical sales.

In California, the Amezcuas and other Mexican meth cartels felt the effects.

According to a DEA report written at the time, the standard, 55-pound drums of foreign ephedrine the traffickers called "tins" were going for as much as $80,000, nearly double the old price. Eventually, the traffickers stopped buying tins altogether, aware that the only people with any to offer were undercover police.

Short on ephedrine, traffickers produced less meth, prompting dealers to dilute or "step on" the product. In late 1995, according to a California Bureau of Narcotics Enforcement internal bulletin, meth samples for the first time were found mixed with MSM, a veterinary analgesic that looks just like crystal meth.

Retail purity plummeted. Nationally, samples of the drug bought undercover fell to only 40 percent to 50 percent pure after peaking at 70 percent to 74 percent.

It was much the same in all the communities where the drug cartels had extended their distribution network. From Oregon to Missouri, meth seized by drug agents tested weaker and weaker.

In August 1995, a final sign of desperation emerged. Investigators in California's Central Valley seized a lab that made simple amphetamine, a much weaker stimulant that can be made without ephedrine. For months afterward, what was

sold as meth was actually the less potent drug, according to law enforcement officials.

Relief came to communities meth had ravaged.

In 1996, for the first time in four years, the number of people in rehab for meth fell in 16 of the 24 states west of the Mississippi River; in five others, the growth in rehab patients dramatically slowed. Each had experienced double-digit annual growth in meth patients from 1992 through 1995. Now, the number was down: 18 percent in Oregon, 19 percent in California, 22 percent in Washington.

Numerous other indicators of meth abuse were falling: meth-related trauma and overdoses nationally; arrests for meth possession in California; car thefts in Salem and Spokane; forgeries in Phoenix and Portland.

The declining purity of meth had suddenly raised the cost of getting high and reduced the drug's addictive allure.

Multiple gauges indicated that meth users responded by cutting back, while some first-time users decided not to make meth a habit.

To people who believe drug addicts will achieve intoxication at any price, the findings would seem surprising. But to the numerous researchers who have found that users are sensitive to changes in price and purity, the outcome is perfectly logical.

"There's no doubt in my mind," said William Woolverton, a leading addiction researcher on primates at the University of Mississippi Medical Center. "If you reduce the dose of methamphetamine, you weaken methamphetamine-taking behavior."

In November 1995, the Amezcua brothers gathered with their underlings in Tijuana. According to a federal indictment, the Amezcua brothers discussed their plight. The disruption in their supply was forcing them to tap new sources. They were feeling the pressure.

**Costly hesitations**

The perfect storm that rocked the Amezcua empire represented a rare opportunity in the battle against meth.

It barely made a ripple with Congress.

DEA officials moved to control pseudoephedrine, ephedrine's chemical sibling and the ingredient they assumed the cartels would try next. But pressed by the pharmaceutical industry, lawmakers resisted.

Meth purity rose again as the Amezcuas made the switch.

In 1996, Congress required pseudoephedrine sellers to register with the DEA, a major change. The law took effect the next year, chasing off some distributors who had supplied the meth trade. Meth purity began to fall, and with it addiction and crime.

Once again, the victory proved short-lived.

The DEA made limited use of its new powers, and the drug cartels slowly found other ways to obtain their chemicals.

In 1998, some pseudoephedrine wholesalers with DEA permits started selling millions of pills to meth traffickers. By 1999, purity was on the rise again.

In 2000, the DEA cracked down, sending dozens of black-market wholesalers to prison. By then, other pseudoephedrine brokers had found a new unregulated source: Canada, where the government had left open the same loopholes Congress had shut four years earlier.

Canada's imports of pseudoephedrine jumped from 34 metric tons annually to about 140 tons in 2001. DEA officials say that additional amount was smuggled into the United States and driven to meth labs in California.

The DEA says Canadian pseudoephedrine imports have declined since. And last month, agents announced a successful operation against a new threat, Canadian distributors of ephedrine powder.

"Breaking up these organizations will dramatically limit the availability of ephedrine in the United States and will have a significant effect on the large-scale production of methamphetamine," Deputy Administrator Michele Leonhart said in a statement.

But the most recent statistics on meth use show the number of addicts is rising, along with drug purity, suggesting that traffickers have found other overseas sources of supply.

Only one independent researcher has closely studied the issue.

In an article published last year in the journal Addiction, James Cunningham analyzed emergency room admissions in Nevada, California and Arizona. That study, based on a narrower range of data than The Oregonian's, reached the same conclusion: Controlling chemicals reduces meth abuse.

Cunningham, of the Public Statistics Institute in Irvine, Calif., said researchers are reluctant to acknowledge the value of law enforcement in curbing drug

abuse. "A lot of people have turned this into an emotional issue or a political issue," he said. "We try to look at it as a health issue."

Former DEA officials who worked to squeeze the chemical supply said they have long understood the basic principle.

"If you don't have all the ingredients to make the pie," said John Buckley, a retired DEA diversion investigator, "the pie isn't going to come out right."

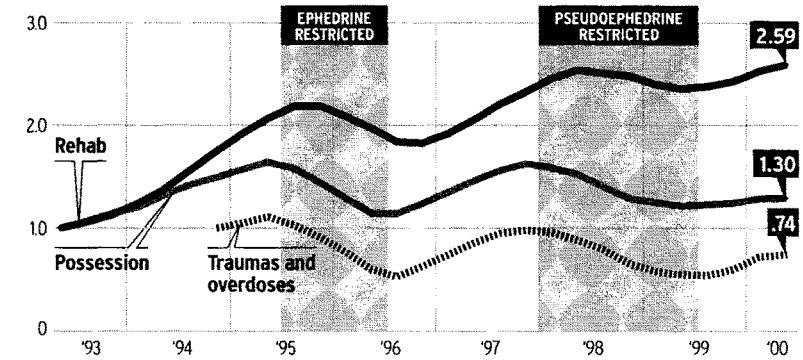
News researchers Lynne Palombo, Margie Gultry and Kathleen Blythe contributed to this story.

Coming tomorrow: Lobbyists and loopholes

## METH ABUSE DROPS AFTER RESTRICTIONS ON CHEMICAL INGREDIENTS

The two major declines in meth purity were matched by falling meth abuse. The chart below shows three indicators: meth possession arrests in California; meth rehab patients in Oregon, Washington and California; and meth-related traumas and overdoses nationally. In this chart, the number "1" denotes the starting value for each statistic. A "2" represents a doubling and "3" a tripling.

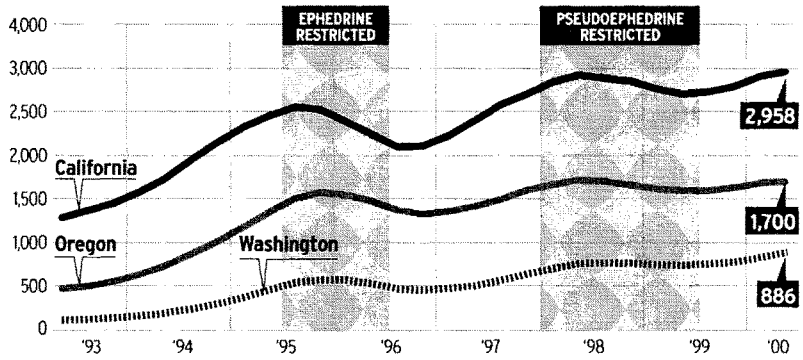
### METH INDICATORS




Sources: California Department of Justice; Drug Abuse Warning Network (DAWN); California Department of Alcohol and Drug Programs; Washington Division of Alcohol and Substance Abuse; Oregon Office of Mental Health and Addiction Services

### REHAB PATIENTS

One indicator with data available across multiple states was the number of meth addicts admitted to rehabilitation programs. In Oregon, Washington and California, the pattern was identical, despite local differences in financing treatment. The chart shows the number of patients in each quarter. California figures were divided by 3 to fit on the same scale as the smaller states of Oregon and Washington.



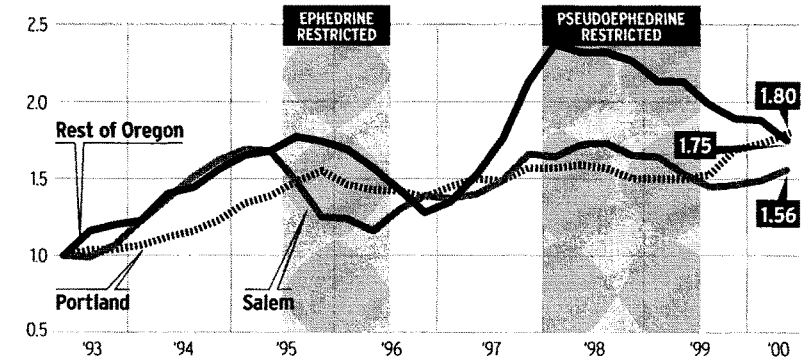

Sources: California Department of Alcohol and Drug Programs; Washington Division of Alcohol and Substance Abuse; Oregon Office of Mental Health and Addiction Services

DERRIK QUENZER, STEVE SUO/THE OREGONIAN

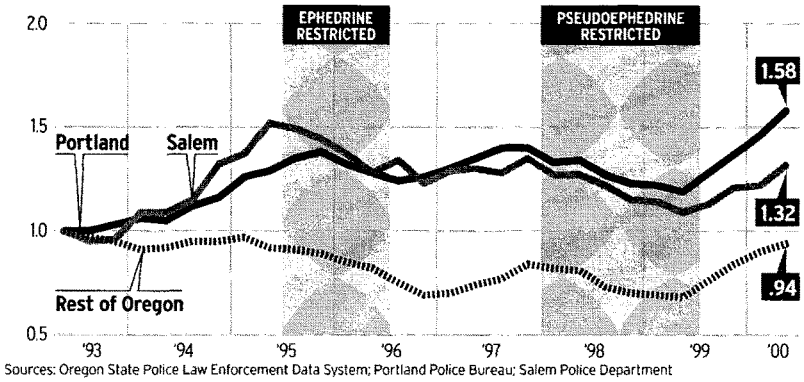
## METH-RELATED CRIMES DROP AFTER RESTRICTIONS ON CHEMICAL INGREDIENTS

In Oregon, police say identity theft, which often appears in crime reports as forgery or fraud, is overwhelmingly committed by meth users. These indicators also fell during periods when meth purity was falling. These charts show crimes reported to police in each location. In this chart, the number "1" denotes the starting value for each statistic. A "2" represents a doubling.

**FORGERY CASES**



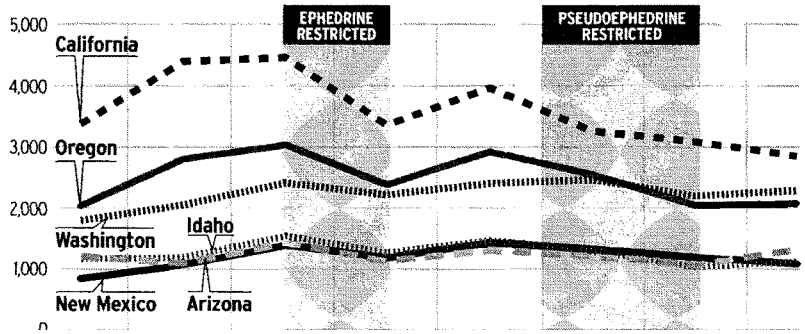

**FRAUD CASES**




Sources: Oregon State Police Law Enforcement Data System; Portland Police Bureau; Salem Police Department

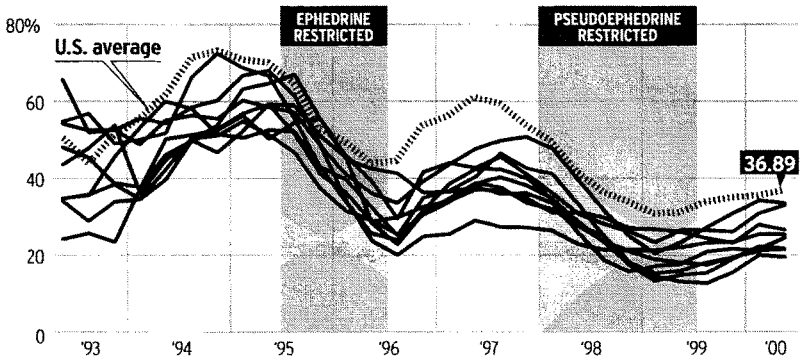
**CAR THEFTS**

In rural areas across the West, vehicle theft – another crime disproportionately linked to meth users – showed a similar pattern. This chart shows annual numbers of stolen cars in counties located outside of metropolitan areas in Arizona, New Mexico, California, Oregon, Washington and Idaho.



## METH POTENCY DROPS AFTER RESTRICTIONS ON CHEMICAL INGREDIENTS

The chart below shows the purity of meth, or how much the drug is diluted with additives. The lines represent purities in Arizona, California, Colorado, Missouri, New Mexico, Nevada, Oregon, Texas and Washington as well as the U.S. average.




Sources: U.S. Drug Enforcement Administration System to Retrieve Information from Drug Evidence (STRIDE); RAND Corp.

DERRIK QUENZER, STEVE SUO/THE OREGONIAN

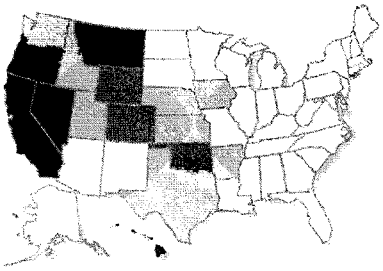
## THE SPREAD OF METH

REHAB ADMISSIONS FOR METH PER 100,000 RESIDENTS

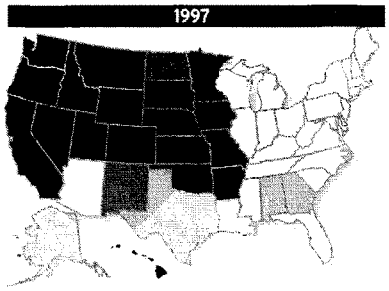
0 to 5 | 5 to 10 | 10 to 20 | 20 to 40 | 40 or more

Methamphetamine abuse, as measured by the number of people entering rehab centers, spread eastward during the past decade while intensifying in the West. The maps below show the number of people treated for meth abuse per 100,000 residents age 12 and older.

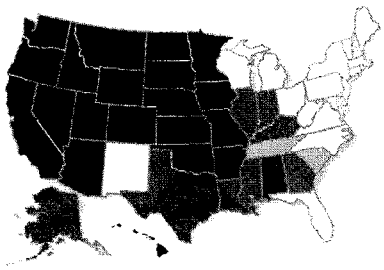
1992



1997



2002



DERRIK QUENZER, STEVE SUO/THE OREGONIAN

## Hidden powerhouses underlie meth's ugly spread

Sunday, October 03, 2004

STEVE SUO

FRESNO, Calif. A cross the West and Great Plains, small-town residents blame the arrival of meth abuse in their communities on the influx of local meth labs.

They are mistaken.

The reality is that 80 percent of meth comes from Mexican drug cartels operating here, in the rural expanses of Central and Southern California. According to the U.S. Drug Enforcement Administration, only 20 percent of the supply is made by local users themselves.

A decade ago, the cartels in California pioneered a technique for industrial-scale production of meth that police dubbed the "superlab."

Built with commercial-grade lab equipment and fueled by hundreds of pounds of chemicals, a single superlab can churn out 100,000 or even 1 million doses of meth in a two-day production run. A typical "user" meth lab can make a maximum of 280 doses at a time.

The cartels' prodigious supply of methamphetamine, sent out across the Plains as far east as North Carolina, created a demand where none existed before. Many of the supply lines lead back to the nation's agricultural powerhouse: the Central Valley of California.

"This," said Carl M. Faller Jr., a Fresno federal prosecutor, "is Colombia for meth."

The influence of the superlabs is overlooked because although they account for the bulk of the drug's production, they represent only 4 percent of the labs. The vast majority of meth labs nationally -- 8,000 of the 8,300 seized in 2001 -- are home-user labs.

Home labs can become an obsessive outlet for users on the multiday runs without sleep known as "tweaking." The designs are primitive and vary widely. They consist of a jumble of over-the-counter pseudoephedrine, household lye and scraped-away matchbook covers. The reaction vessel usually is a jelly jar. The output might provide a cook $250 to $500 worth of meth to sell, with two weeks' worth left over for personal use.

Although tweaker labs are costly to clean up when they explode or spill, their role in supplying meth to U.S. users is minor. The main culprit is the superlab.

**Bubbling glass globes**

California superlabs achieve a level of sophistication, uniformity and efficiency seldom seen in tweaker labs.

The superlab's signature is a globe-shaped piece of glassware that drug agents call a "22." Designed for scientific research, the 22-liter reaction vessel could hold the contents of 11 two-liter soda bottles. The 22 sits in an aluminum cradle lined with heating coils. The cradle and globe together sell for $3,000 to $4,000.

Inside the glass ball, a blood-red brew of pseudoephedrine, red phosphorus and hydriodic acid reacts to form meth. The temperature dial is turned up to set the mixture bubbling, then down to cook. Orange hoses stretch like octopus arms from the neck of each 22 to a box filled with cat litter, which absorbs reaction gases.

Jerry Massetti, a chemist with the California Bureau of Forensic Services, recalled the first rumors of such monster labs in San Diego in the early 1990s.

"You'd wonder whether it was an exaggeration," Massetti said. "Then you'd hear similar stories of labs in Riverside, Orange County, Los Angeles."

Then the monster headed north, he said, "like a shadow passing over the landscape."

In the Central Valley, the highly standardized superlabs arrived en masse one week in July 1992, according to Massetti's notes and a journal article he wrote at the time. The labs, he wrote, "corroborated rumors about multiple tons of ephedrine being processed in this way."

The biggest Massetti ever saw came eight months later, in a Tulare County fruit-packing shed. The lab was so enormous that operators used a forklift to crush all the cans of Freon emptied during manufacturing. Twelve glass 22s were strung together, creating a capacity of 144 pounds of pure meth per batch. Cut to street purity, that could keep 21,000 serious addicts high for a week.

The labs are so standardized that the first time police found high-thread-count Martha Stewart sheets -- used to filter solid meth from surrounding liquids -- in one lab, identical sheets were discovered the next day in a lab 100 miles away. The smallest detail, down to the way in which hoses are duct-taped together, is replicated from one superlab to the next.

Police say the cookie-cutter approach reflects the guiding hand of Mexico-based drug cartels, which run the labs in California and distribute the finished product across the country.

Labor comes from migrant workers. California drug agents call these lab operators "mopes" -- police lingo for low-level henchmen.

The mopes don't use meth but hire themselves out in standing crews of four or five, available for a weekend's hard work cooking the drug. From the Central Valley, a typical crew of mopes could travel across Pacheco Pass through the Coast Range on a Friday night to the Bay Area. They'd pick up a stash of chemicals from a San Jose storage locker, then return to a small valley town such as Merced, where their employer would secure a secluded barn or farmhouse by bribing a ranch foreman.

After laying in a supply of groceries, the mopes would work for two days without sleep to monitor the delicate reaction. A misstep could cost $50,000. Some are told their families in Mexico will be killed if they speak to the police. At times, drug agents have come upon mopes in a lab padlocked from the outside.

At the end, a supervisor arrives to haul away the finished meth for delivery.

In Medford, Ore., police say 15 major dealers ferry the drugs regularly from the Central Valley. In Woodburn, Ore., police once seized 30 pounds of meth shipped directly by a top member of the Amezcua cartel in Southern California. The local dealers had customers up and down Interstate 5, from the Portland suburbs to the Grants Pass area of Southern Oregon.

**Patron saint of traffickers**

The Central Valley offers a perfect locale for the mopes to hide their work.

Blinding dust billows across county roads. Derelict outbuildings, rusting farm implements and 100-foot stacks of wooden pallets dot mile after mile.

Through long experience, the 20-member Fresno Methamphetamine Task Force has learned the routine of catching mopes in the act.

Team members cull junk mail at lab waste dumps for addresses. They watch abandoned farmhouses where the occasional car has been seen to come and go. On a stakeout, they'll ask permission to park in a rancher's yard by saying they're investigating the theft of farm implements.

If they're lucky, they'll sneak up on what Fresno Sgt. Don Mitchell calls a "real nice lab" -- 22s bubbling, surrounded by a smell some liken to rotting citrus.

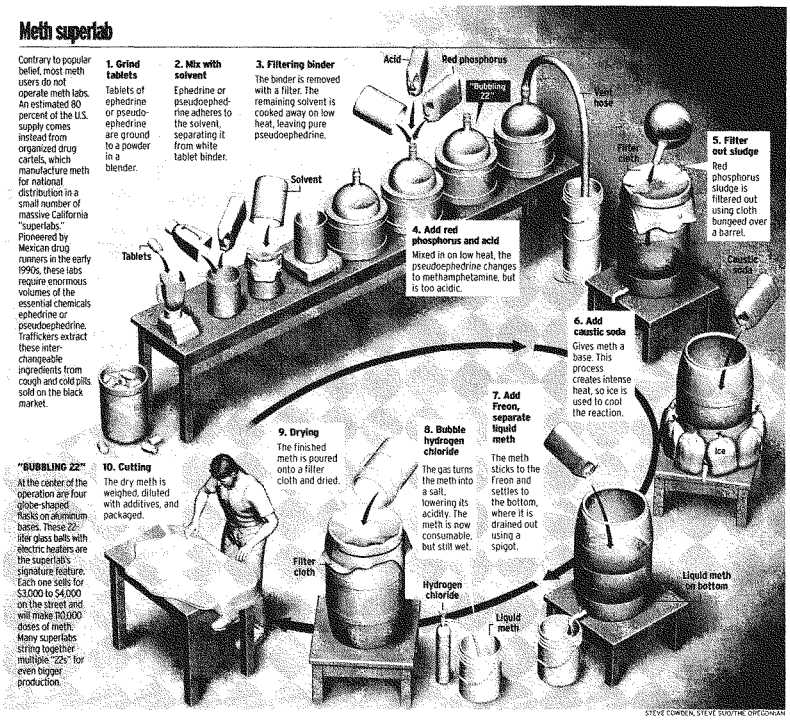
Agents tell of moonlit "low crawls" with camouflage and automatic weapons through rows of grapevines; of the leg broken in a fall through a rotting barn roof; of mopes who ran, or "leg bailed," and ones who slowed down long enough to be deported.

Whether the mopes get caught or get away, they often leave behind relics of Jesus Malverde -- the mustachioed 19th-century bandit whom Mexican traffickers have made their patron saint. The relics offer prayers like this one, printed on a container of incense:

"You that dwell in heaven near God, hear the sufferings of this humble sinner.

"Oh Miraculous Malverde, Oh Malverde my Savior, grant me this favor and fill my heart with joy.

"Grant me good health, Lord, give me peace, give me comfort, and I will rejoice."




STEVE COWDEN, STEVE SUSOTHE/ DPEGOMAN

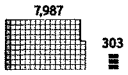
OregonLive.com
Everything Oregon
The Oregonian

## HOME METH LABS AND SUPERLABS COMPARED

Home meth lab ■ Superlab

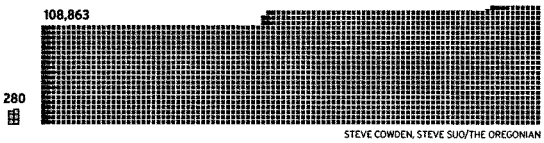
**Labs seized**

Each square equals 50 labs seized in 2001.




**Lab production**

Doses produced every 48 hours by typical home lab and small superlab. Each square equals 50 doses.




STEVE COWDEN, STEVE SUO/THE OREGONIAN
10/3/04

**Years of attempts by politicians, prosecutors and police to curtail sales of the two essential ingredients to make meth are hamstrung by...**

## Lobbyists and loopholes

Monday, October 04, 2004

STEVE SUO

In his office on Washington, D.C.'s bustling Connecticut Avenue, five blocks north of the White House, drug lobbyist Allan Rexinger was scanning the Congressional Record one September day in 1986 when two words stopped him short.

"Ephedrine." "Pseudoephedrine."

The U.S. Drug Enforcement Administration wanted to require companies to keep sales and import records for these and 12 other chemicals used in making illegal drugs. Executives would have to give the DEA the documents when asked.

From his seven years protecting the interests of the pharmaceutical industry, Rexinger knew that ephedrine was important to sellers of nonprescription asthma and diet pills. Even more important, pseudoephedrine was the leading ingredient in the nation's $3 billion cold medication market. Every major drug firm had a brand.

The controls, Rexinger suspected, were only the beginning, the first step toward making cold medicine a prescription drug.

The DEA had to be stopped.

Rexinger's group prepared a counterattack. It was the first of many that would stall three major efforts over the next decade to regulate products sold by one of Washington's most influential industries.

The lobbyists would repeatedly invoke the needs of tens of millions of cold sufferers and asthmatics who were buying pseudoephedrine- and ephedrine-based products over the counter. Meanwhile, they would forge alliances with Capitol Hill staffers, members of Congress and White House officials who would help them thwart the DEA's plans. It was, the lobbyists believed, the only way to cope with a bureaucracy deaf to industry concerns.

Whenever federal officials tried to tighten control over the chemicals used to make methamphetamine, Rexinger and his colleagues swung into action. Again and again, DEA officials agreed to compromises that left open one or more crucial loopholes for traffickers to obtain their ingredients -- the bulk of which are made in only nine factories worldwide.

A small group of federal officials, prosecutors and local cops understood the inner workings of the methamphetamine business and the threat it posed to Oregon, California and other states in the West. But their push for tougher laws was episodic, and they were repeatedly outmaneuvered by the pharmaceutical industry, which had far better access and influence over key decision-makers.

Meth traffickers relentlessly exploited the loopholes lawmakers left open.

By 1997, when the DEA completed its incremental struggle to control all levels of the trade in meth-related chemicals, an estimated 5 million Americans had tried methamphetamine.

As Rexinger studied the DEA's first proposal to impose controls that fall day in 1986, he picked up the phone and sounded the warning.

Over the coming months, Rexinger would confront the bill's congressional sponsors and challenge the DEA. Ultimately, someone would have to persuade the White House to intervene.

**The idea man**

The legislation that so riled the drug industry in 1986 was an idea scrawled on a cocktail napkin just a year before. Its author: a midlevel bureaucrat convinced that he could put drug traffickers out of business by cutting off the chemicals they needed.

Deputy Assistant Administrator Gene Haislip was an idea man. As an ambitious young attorney in the DEA Office of Chief Counsel, he had quickly set himself apart by suggesting new areas for legislation and then drafting it himself.

When Haislip was tapped in 1980 to run the agency's tiny Office of Compliance and Regulatory Affairs, he began looking for ways to expand its mission beyond policing prescription drugs. His first opportunity came from Quaalude, a widely abused sleeping pill.

Haislip concluded that 90 percent of the world production of Quaalude's legal chemical ingredient, methaqualone powder, was being bought by Colombian drug lords.

Haislip and his staff visited the countries that made methaqualone -- China, Germany, Austria -- and enlisted their help in halting the flow. Separately, Congress banned domestic sales of the prescription version of Quaaludes, which were made by just one company.

By 1984, Quaaludes had all but disappeared from the U.S. marketplace. It was the first time the DEA could claim total victory over a drug.

Haislip was certain the Quaalude story could be repeated. Flying home from Europe one day with his boss, Haislip sketched out a plan to place all drug-related chemicals under the same sort of system that tracked prescription drugs and narcotics.

Every chemical used in the illegal trade -- from solvents that refined cocaine to essential ingredients in synthetic drugs such as PCP, LSD and methamphetamine -- would fall under the Controlled Substances Act. Anyone who handled such chemicals would have to register with the DEA; each transaction from factory to final use would be reported to the government. Exports and imports would require permission from Haislip's newly renamed Office of Diversion Control.

Given the go-ahead from DEA brass, Haislip gathered his staff at DEA headquarters one day in 1985. "Today, gentlemen, we are going to draft a new law," he remembers saying.

From the beginning, Haislip had to adapt his bold proposal to what the DEA bureaucracy would accept. DEA officials reminded him that the agency had been buried in paperwork when Congress demanded reports on all sales of a chemical used to make the hallucinogen PCP.

Haislip scaled back. Companies buying and selling the key chemicals involved in the drug trade would be required to retain records that could be shown to DEA agents on demand.

Haislip also winnowed the list of chemicals to be controlled from dozens to 14, including both ephedrine and pseudoephedrine. Meth cooks were using ephedrine at the time, but DEA chemists knew pseudoephedrine would work just as well.

The legislation was ready by fall 1986, in time for final debate on a sweeping drug bill moving through Congress.

On Sept. 14, President Reagan and his wife, Nancy, called for a crusade against drugs.

"Each of us has to put our principles and consciences on the line -- whether in social settings or in the workplace -- to set forth solid standards and stick to them," Nancy Reagan said in a 20-minute, televised address. "There is no moral middle ground."

Nine days later, Senate Majority Leader Robert Dole, R-Kan., introduced the administration's chemical control legislation as a potential addition to the omnibus House drug bill about to be debated in the Senate.

Haislip was confident his idea was on a fast track to the president.

**Battle is drawn**

Rexinger said he felt blindsided when he read about Dole's bill in the Congressional Record.

His employer was the Proprietary Association, a trade group representing the nonprescription divisions of the nation's largest pharmaceutical companies.

In the early 1970s, the Food and Drug Administration had launched a comprehensive study of over-the-counter drug ingredients. It ultimately led the agency to approve dozens of prescription-only products for sale without a doctor's advice, including pseudoephedrine and nine other cough and cold ingredients in 1976.

Over the next 10 years, U.S. sales of pseudoephedrine products grew so fast that they outstripped the production capacity of the world's main producers in Germany and Czechoslovakia.

Rexinger made an appointment with Dole's staff. In the Republican leader's office, he handed an aide a package of Sudafed. From Rexinger's perspective, it was a proven, safe, effective and legitimate product that consumers needed.

"Your bill," Rexinger recalled telling a Dole aide, "just made this product illegal."

Dole could not be reached for comment, and his former chief of staff, Sheila Burke, did not remember the episode. But Rexinger recalled being told by a Dole staff member that the bill was not intended to harm the industry.

Weeks later, when Congress passed sweeping drug legislation with Dole's support, it did not include Haislip's chemical program. The final version asked the DEA to study the issue and report back by spring. Reagan signed it into law on Oct. 27, 1986.

Haislip still had momentum. But Rexinger had bought time.

**The strategic compromise**

Rexinger and his boss at the time, James D. Cope, say they spent the next months trying to get the DEA's attention. They made appointments to see Haislip.

Rexinger and Cope, president of the drug association, felt their usual contacts at the Food and Drug Administration understood the needs of legitimate commerce. But they recall a much cooler reception at the DEA.

"DEA's position was, 'Look, this is too bad, but this is the only way we can really get a handle on this situation. We've got to know where this stuff's going so we can make the busts,' " Rexinger said.

Cope said their demeanor indicated, "We'll meet with you, but someone told us we have to meet with you bastards, and this is the way it's going to be."

Then, something changed.

"It took a telephone call," Rexinger said, "to the highest levels of the United States government."

"The pharmaceutical industry had well-placed people, and it was necessary to inform the White House that we weren't making the progress that we felt we should be making with DEA.

"The White House basically intervened on our behalf," Rexinger said.

Cope confirmed that a White House staffer arranged for a meeting with the DEA but didn't recall who called whom. Haislip said he was unaware of any phone call but remembered that the meeting with the industry was arranged by the Executive Office of the President.

DEA officials met with industry representatives in the Indian Treaty Room of the Old Executive Office Building. Rexinger said White House involvement in the issue sent a clear message.

"It basically got DEA off the mark," Rexinger said. "After that, we had useful negotiations with DEA.

"They realized that the pharmaceutical industry was willing to do what was necessary to protect the interests of legitimate drugs," Rexinger said.

In April 1987, Attorney General Edwin Meese III reported back to Congress with a new legislative proposal. It looked identical to what the administration had proposed just six months before, with one difference.

It exempted from regulation any chemical -- such as ephedrine and pseudoephedrine -- turned into a legal drug product. Importers of raw ephedrine and pseudoephedrine powder had to keep records of their purchases and sales. Sellers of finished pills containing ephedrine and pseudoephedrine, meanwhile, did not.

The 31-word exemption left the drug industry out of the regulation, which is what Rexinger wanted.

"I don't recall why, but I feel like we had to take it," Haislip said.

"Certainly we didn't like it, and we knew what it was about and where it was coming from," Haislip said. "But sometimes you have to make a strategic decision. You've got to pick your fights. This is the way it is in this city."

While Haislip was negotiating with the industry, prosecutors on the West Coast were developing their own ideas about how to choke the chemical supply.

In San Diego, Deputy District Attorney Hugh McManus had built a reputation for aggressively prosecuting dozens of major meth dealers. McManus noticed that when California legislators placed restrictions on ephedrine sales in 1987, the traffickers adapted, switching to unregulated chemicals.

McManus sat down and drafted a proposal for federal legislation to get ahead of the traffickers. Sellers of ephedrine and pseudoephedrine in any form, including finished cold pills such as Sudafed, would have to report all sales to the DEA. The agency also would have the power to impose controls on any comparable chemicals used by traffickers -- without going back to Congress.

In the fall of 1987, U.S. Rep. Bill Lowery, R-Calif., introduced McManus' bill and invited the California prosecutor to book a flight to Washington. The bill he wrote was headed for a hearing alongside Haislip's.

**A prophetic plea**

On Sept. 16, 1987, two years after the first drafts, Haislip sat before the House Judiciary Committee's Subcommittee on Crime to explain the compromises he had crafted.

Some members asked why he hadn't attempted something more ambitious, like computerized tracking of every chemical sale.

"I am a little surprised, frankly, that you would only go this far," said Rep. Larry Smith, D-Fla.

"Look at the number of labs you were able to break last year without any of this," Smith said. "Just think of how many you could with it! Yet, I am looking, and I see a lot of things absent from the legislation."

Haislip chose his words carefully. After all, his original proposal had gone much further. He told Smith the bill was a delicate balance of competing interests. The DEA's aim, he said, was to fight crime without hindering legitimate commerce.

"We have perhaps designed a more modest approach," Haislip said, "being conscious of the burdens on industry."

Smith didn't like that answer.

"What the hell does the modest approach have to do with the reality of law enforcement when it comes to drugs?" Smith said.

"I would be more than happy to work with the chemical manufacturers," he said. "But frankly, I am interested in getting rid of drugs, and I really am tired of losing."

A few days later, the committee followed up with a list of questions for Haislip's boss, DEA Administrator John Lawn. The committee had seized upon the central compromise that Haislip made with the industry: regulating powder but not pills containing ephedrine and pseudoephedrine. Wasn't this a loophole that would allow drug traffickers to get the same chemicals in a different form?

"Yes," Lawn responded. ". . . It is highly unlikely, however, that this would occur."

The next day, Congress heard a different story from McManus. The DEA's strategy of regulating some chemicals while exempting others, he told Congress, gave meth cookers a road map.

"Merely listing the now-known precursors gives these imaginative chemists a lot of maneuvering room," McManus said, "allowing them to come up with a new, unregulated precursor even before the new legislation is printed in the law books."

McManus urged the committee to broaden the legislation that Haislip had written, authorizing the DEA to regulate chemical substitutes adopted by meth cooks. Otherwise, Congress would have to repeatedly push through new legislation as the criminals adapted.

"Meanwhile," he said, "there is going to be another ton of methamphetamine shipped out of San Diego County."

The chairman thanked McManus for his testimony. Congress went on to approve Haislip's bill in late 1988 without McManus' suggested changes. It took effect in August 1989.

Defeated but not surprised, McManus returned to San Diego.

"I knew before I got there," McManus said. "It's like one of these deals, other things I've been involved in as a DA, where everybody tells you, 'You can take this case to trial, but you're going to lose in the end.' The fix is in, so to speak."

Within months, McManus was proved right about the drug traffickers.

**Finding the loophole**

Ronald Lee Henslee was a prodigious supplier of California's meth superlabs. The San Diego resident was caught with 1,200 pounds of ephedrine powder in 1989 but escaped a prison sentence, court records show. He was jailed later that year for violating his probation but continued to coordinate ephedrine shipments from prison through telephone calls to his girlfriend, according to prosecutors.

The federal investigation into how Henslee obtained his ephedrine led agents to a disturbing discovery: The loophole in Haislip's law -- which left ephedrine in pills unregulated -- already was being exploited.

Henslee's supplier, Pittsburgh-based Nationwide Purveyors, produced ephedrine pills called "Mini White Thins" for sale in magazines such as Hustler and High Times.

Before Haislip's law took effect in August 1989, Nationwide Purveyors had a separate arrangement to supply Henslee with 55-pound barrels of raw ephedrine powder. As soon as the law required record-keeping of ephedrine powder sales, Nationwide Purveyors began shipping pills called "Mini-Thin Barrels," which were exempt from regulation.

Nationwide Purveyors, its owner, Henslee and others eventually were convicted of supplying about 4 metric tons of ephedrine to the meth trade over two years -- enough to make more than 49 million doses of meth.

The case surprised Haislip.

For the most part, his law was having a deterrent effect. By late 1990, U.S. exports of cocaine-refining solvents to Latin America had plummeted. And the total number of meth labs seized by drug agents had fallen.

But lawmakers in the West already were demanding that the government do more. They introduced legislation to expand Haislip's law by requiring more information from chemical distributors.

"We have, most particularly on the West Coast, a problem now," Sen. Slade Gorton, R-Wash., said in 1990. "We seek to address that problem now."

Haislip resisted making radical changes to a law that he so recently had ushered onto the books and that his staff was still learning to enforce. On the other hand, Haislip could see from Nationwide Purveyors and other cases that the meth trade's shift to ephedrine tablets would have to be addressed.

Back at the Proprietary Association, Rexinger was not happy about reopening the issue. To him, it seemed as though Haislip and the DEA were working behind the scenes to unravel the compromise they had struck.

"They would just keep going back to the Hill advocating their position without regard for the legitimate pharmaceutical industry," Rexinger said. "I would get rumors of that from staffers up there.

"I would have to go up there," he recalled, "and I'd just have to pull the plugs on them."

**Meth explosion**

It took Haislip three years to close the loophole that made ephedrine pills common currency in the meth trade. While he negotiated with the pharmaceutical industry and prodded lawmakers, trafficking in methamphetamine exploded.

The Mexican cartels developed an additional source for ephedrine, buying bulk powder from overseas suppliers.

A flood of high-potency meth rolled eastward, through the Rockies and into the Plains. Between 1992 and 1994, the purity of meth on the street skyrocketed, from 46 percent all the way up to 73 percent. At the same time, the number of people entering rehab for meth doubled.

In 1993, after the DEA struck a new compromise with Rexinger's group, Congress passed legislation that required sellers of ephedrine tablets to keep records of customers, report suspicious sales and register with the DEA. It was phased in from April 1994 through August 1995.

The DEA immediately cracked down on the trade in ephedrine-based pills. And drug agents cut off the network of overseas connections that had delivered 170 metric tons of ephedrine to the cartels in less than two years -- enough to make more than 2 billion doses of meth.

Haislip's staff flew to India, the Czech Republic and Switzerland. Within months, those countries began enacting stricter export controls on ephedrine.

The combined domestic and overseas efforts prompted a steep drop in the purity of street meth. Indicators of meth abuse -- from the number of people in rehab to emergency room patients with meth in their systems -- plummeted.

But already, the cartels were changing tactics.

To get the pharmaceutical industry to accept restrictions on sales of pills containing ephedrine, Haislip had agreed to leave pills containing pseudoephedrine -- a potential substitute in making meth -- unregulated. For meth cooks in California, it was the next best thing.

**The new ingredient**

In the spring of 1995, DEA agents needed five tractor-trailer trucks to empty the warehouse at Clifton Pharmaceutical, a Pennsylvania pill maker whose owner had moved as much as 70 metric tons of ephedrine tablets to meth traffickers. The owner was headed to federal prison for five years.

Yet the news was not all good.

Federal agents sifting through Clifton's records discovered that the company had switched to buying huge volumes of pseudoephedrine after the new law took effect. In less than 18 months, the company purchased 110 tons and converted most of it into unregulated pills.

It was, by then, a familiar story to Haislip and his staff. Twice they had struck compromises with the drug industry, agreeing to regulate one meth ingredient and not the other. Both times, meth cooks had seized on whatever the DEA left unregulated, just as McManus, the San Diego prosecutor, had predicted in 1987.

Haislip sent his chemists to the grocery store to buy various types of cold medicine containing pseudoephedrine -- pills, capsules, liquids. The technicians returned to the DEA lab and started trying to extract useable pseudoephedrine from each product.

"The lab was able to make methamphetamine out of every size, shape and form," said Terry Woodworth, the agency's former deputy director of diversion control.

On Halloween Day 1995, the DEA announced plans to eliminate the loophole Haislip had accepted under pressure from Rexinger a decade before. Pseudoephedrine products, the agency said, would be treated like all other methamphetamine ingredients.

Haislip's proposed rule seemed modest: Manufacturers and wholesale distributors would have to get DEA licenses and keep records if they sold more than 400 tablets of pseudoephedrine in one sale -- enough for a 100-day cold at the normal dose.

But for drug executives, this was the moment Rexinger had warned about from the beginning.

An outright ban or prescription-only status for pseudoephedrine seemed easily imaginable.

**A bag of pills**

The pharmaceutical industry turned to a longtime ally, a member of Congress with enormous sway over DEA activity: Sen. Orrin Hatch, the Utah Republican

who chaired the Senate Judiciary Committee, had also supported key legislation promoting generic drugs and curbing federal regulation of dietary supplements.

Within weeks of Haislip's announcement, Hatch aide Michael Ashburn was dispatched to work on the pseudoephedrine issue. Ashburn, a University of Utah professor of medicine assigned to Hatch on a one-year fellowship, challenged the DEA to prove that traffickers were switching to cold pills.

"They said, 'We know it's the case,' " Ashburn recalled. "We said, 'Show us. Show us the money, show us a list of arrests that came from where you found a popular brand of pseudoephedrine sitting on the floor.' "

DEA officials had to admit the shift had only recently begun. Pseudoephedrine had been found in 22 percent of labs busted in 1995, up from 11 percent the year before. But history told the DEA that traffickers would quickly make the transition.

"There was just no question in our minds that they were going to go there," Woodworth said.

Facing resistance from the industry, the DEA found its own powerful friend in Sen. Dianne Feinstein, a California Democrat who was under pressure from her state's drug agents and prosecutors to do something about the exploding meth problem.

In March 1996, Feinstein introduced a bill proposing enormous penalties for companies whose products repeatedly ended up in meth labs. The first occurrence would prompt a warning, the second a fine of as much as $250,000. The third time, the DEA could shut the company down. The agency wouldn't have to prove intent, only that the company had been warned.

The bill languished in Hatch's committee.

Feinstein sent her aides on a shopping trip to buy as many pills as the DEA's proposed regulations would allow in a single transaction. They returned with a bulging bag, two staffers recalled.

Feinstein summoned a group of drug executives to her office one day. Her staff brought in the shopping bag, stuffed with packets of pseudoephedrine, and dumped it on the table. Surely, Feinstein said, there must be some quantity that the executives considered legitimate for the DEA to police.

By late summer 1996, Hatch and Feinstein reached a compromise.

Sellers of pseudoephedrine would be subject to DEA registration and record-keeping -- unless they sold only pseudoephedrine tablets in individually wrapped

"blister packs." Meth cooks so far seemed to prefer pills in bottles, because blister packs took time to empty.

Feinstein's proposed "three strikes" rule, requiring progressively higher penalties each time a company's products were found in meth labs, was watered down to affect only companies that showed "reckless disregard" for where their products went.

The deadline for distributors to start registering with the DEA was pushed back a year.

Hatch called the compromise a "more fair approach" than the DEA's, which might have created so much red tape that companies would stop selling pseudoephedrine products.

By the time the Hatch-Feinstein law governing pseudoephedrine took effect in late 1997, the traffickers' switch to pseudoephedrine was complete. Agents seized 422 pseudoephedrine-based labs in 1996, up from 93 the year before. Legal imports of pseudoephedrine had jumped 160 metric tons in three years, an increase of 41 percent.

**"Greed gets ahead of safety"**

In the 12 years that had passed since Haislip drew up his idea on an airline cocktail napkin in 1985, the issue had come full circle.

The DEA now had nearly all the powers Haislip had given away in order to build support within the DEA and in Congress. He retired in 1997, just as the agency was preparing to register pseudoephedrine dealers for the first time.

Each expansion of Haislip's law had made a significant dent in the meth trade, though only temporarily. In a decade of compromises on the issue, meth grew from a relatively small West Coast trend to an epidemic that claimed users from Oregon to Oklahoma.

The traffickers continued to adapt. A DEA study reported that blister packs -- the sole unregulated aspect of the pseudoephedrine trade -- were found in 47 percent of meth labs seized in 1999 and 2000.

Feinstein now acknowledges the shortcomings in the law she wrote and has introduced new legislation to repeal that loophole.

The "reckless disregard" provision did not work out as planned, either. DEA officials say it has not resulted in a single fine against a pseudoephedrine supplier. Feinstein, told by The Oregonian that companies had stayed in

business despite 30 to 40 warning letters, vowed to push additional legislation lowering the DEA's burden of proof against pseudoephedrine distributors.

Feinstein said the industry's influence remains an obstacle.

"There's no question there's a problem. There's no question that pharmaceutical companies allow the problem to happen," Feinstein said.

"This is one issue where greed gets ahead of safety."

Hatch said he considers meth "a vicious drug" and takes seriously the need to battle the trade. But he said he remains wary of giving the DEA too much influence over sales of "a good cold medication."

"I would like to find a way to solve it," Hatch said of the meth problem. "On the other hand, we shouldn't let a bureaucracy unilaterally, without legislative authorization, interfere with the marketplace."

Haislip said he now recognizes that some of the compromises he accepted in the interest of progress created a less-than-ideal system.

"At the time that it occurred, the truth is, we would not have seen it as, 'This is the Achilles' heel building in here,' because we really didn't know that. I had the strong hope that it wouldn't happen. I guess that was a little naive."

Rexinger, the former lobbyist, said it would have made no sense to regulate all legitimate cough and cold products at once, simply on the chance that criminals might misuse them in the future. Getting the ear of the White House allowed the industry to make its case.

"Mind you, there was nothing bad going on here," Rexinger said of his legwork in 1986. "I mean, this is the way government works. You use your contacts, and you try to get someone's attention."

McManus, who pleaded unsuccessfully with Congress in 1987 to regulate all potential meth ingredients immediately, retired in 1992. He recalled that he was far more successful locking up drug dealers than he ever was lobbying Congress.

"I wish that I knew the way to have gotten around it," McManus said of the pharmaceutical industry's maneuvering.

"I wish," he said, "I could have done a lot more."

*Jim Barnett of The Oregonian contributed to this report. News researcher Margie Gultry also contributed.*

## REGIONAL BIAS: METH VERSUS COCAINE

The politics of methamphetamine have been shaped by geography. Lawmakers from the East, Midwest and South focused on cocaine – the most heavily abused drug by far in their home states. By contrast, more than 90 percent of people treated for meth abuse live west of the Mississippi River.

**Oregon leads the country, with 28 meth users in rehab for every 10,000 residents.**

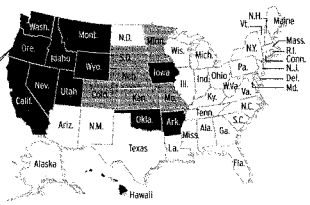
NOTE: West Virginia data only available for two years.

Source: U.S. Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set

### METH

The map indicates the number of meth users in rehab per 10,000 state residents age 12 and older. Figures are annual averages for 1998-2002.

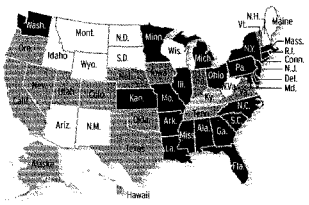
Less than 4 | 4 to 8 | 8 to 16 | 16 or more




### COCAINE

Cocaine users in rehab per 10,000 state residents age 12 and older.

Less than 4 | 4 to 8 | 8 to 16 | 16 or more

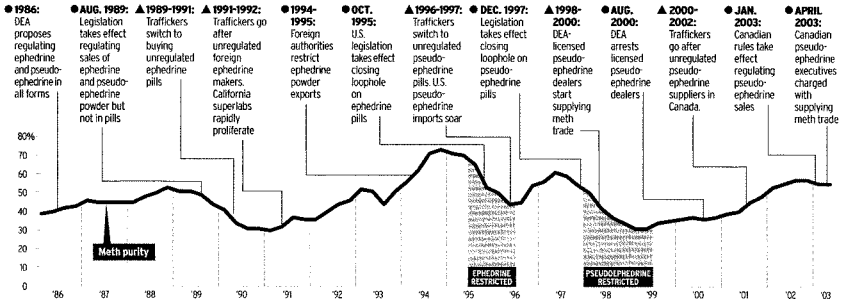



DERRIK OUDNZER, STEVE SUO/THE OREGONIAN

## HOW LEGISLATION CHANGED METH PURITY

● Legislation/law enforcement ▲ Traffickers

The methamphetamine supply is uniquely susceptible to disruption by government, as revealed by changes in the drug's purity over the past two decades. Whenever new legislation limited access to the essential chemicals, production slowed, and traffickers watered down their product. The declines in purity began between the time Congress voted to impose tighter scrutiny over legitimate chemical sales and when the rules took effect. Traffickers always adapted because lawmakers left them loopholes to exploit, and federal drug agents were slow to enforce the laws that were enacted.




Source: Purity estimates from RAND Corp., based on U.S. Drug Enforcement Administration data.

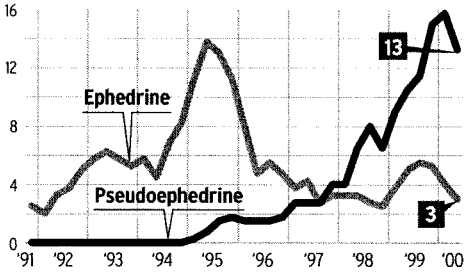
DERRIK QUENZER, STEVE SUO/THE OREGONIAN

## FEDERAL CASES SHOW SHIFTING INGREDIENTS

The number of people charged with ephedrine smuggling or trafficking quarterly peaked in 1995, tapering off as tighter regulation of the meth ingredient drove traffickers to pseudoephedrine. The chemical sibling of ephedrine was a perfect substitute and its sales were subject to less federal scrutiny.

Note: Each point represents an average of the preceding four quarters of data.
Only court filings that specified the chemical are counted.

Source: Lexis-Nexis index of federal court cases.




DERRIK QUENZER, STEVE SUO/THE OREGONIAN

**By rubber-stamping rather than stamping out dubious chemical distributors, issuing flurries of warning letters without penalties, DEA mounts a mere . . .**

## Token deterrent

Tuesday, October 05, 2004

STEVE SUO

Thomas Narog stood outside his rented storage unit in Fort Lauderdale, Fla., one day in July 1999 while a federal inspector checked the lock.

The 66-year-old semi-retired mortgage broker wanted to go into a new business, but he needed the U.S. Drug Enforcement Administration's approval. He wanted to sell pseudoephedrine pills from the storage unit.

While Narog had no background in pharmaceuticals, he also had no criminal record, and neither did the man he claimed as his sole customer. The inspector handed Narog some brochures that warned pseudoephedrine can be used to make methamphetamine, then told him to report any suspicious orders to the DEA.

Two weeks later, Narog had his permit, and Seaside Pharmaceutical Co. was in business.

It proceeded to supply millions of pseudoephedrine pills to meth labs, federal law enforcement officials say.

The Narog case, outlined in DEA and court records, illustrates a central reason why the nation failed to keep vital chemicals from meth traffickers in the 1990s.

The DEA did not make full use of the powers it had won from Congress to shut down illicit sales of the key meth ingredients. Instead, it created an honor system that took distributors such as Narog at their word.

Some lied.

Narog was charged with supplying the meth trade, and his trial exposed gaps in DEA procedures.

The DEA inspector who reviewed Narog's application testified that he never contacted Narog's purported customer, an investor in a Florida grocery chain.

That customer, in turn, told the court that Narog had spoken to him about selling cigarettes, not pseudoephedrine.

DEA agents began watching Narog eight months after granting his license, when his TruChoice tablets started showing up in huge quantities at California meth "superlabs." By then, DEA officials say, Narog had bought 17 million pseudoephedrine pills -- enough to treat 600,000 colds for a week or make a day's supply of meth for 3 million people.

Prosecutors said Narog's business was part of a cross-country network of warehouses and intermediaries that routed the pseudoephedrine into California via Oregon. Narog was convicted in 2002 of supplying the meth trade, but an appeals court this year ordered a new trial because of improper jury instructions.

Narog applied for DEA registration under a federal law designed to prevent meth traffickers from obtaining the chemicals they needed. Companies that wanted to sell pseudoephedrine were typically asked to name their proposed customers and suppliers.

But the drug agency's inspectors did not always require answers. And they did not consistently verify what they were told.

To keep a DEA permit, a dealer was supposed to record all purchases and sales, and report any suspicious customers.

But the drug agency rarely did random audits to see whether companies were complying, a review of DEA and court records shows.

The law, which took effect in 1997, empowered the agency to revoke a company's license if allowing sales to continue was "inconsistent with the public interest."

However, DEA records obtained by The Oregonian through the Freedom of Information Act show that 35 of 129 companies whose products were found in meth labs received three or more warning letters without losing their licenses. One registered pseudoephedrine seller on the East Coast remained in business after 47 warning letters -- most recently in May 2003, the records show.

More than 200 DEA permit-holders did business from houses, mobile homes or apartments, The Oregonian's investigation found. The newspaper found at least 11 companies listed addresses that are public storage facilities.

DEA and court records show that the agency gave pseudoephedrine permits to at least two companies convicted of federal crimes. One was convicted of interstate transport of stolen goods, the other of sales of counterfeit pharmaceuticals.

The DEA allowed some pill manufacturers to keep licenses despite repeatedly selling large quantities of cold tablets to people who were later convicted of meth trafficking.

Several current and former DEA officials said the drug agency has historically placed a greater emphasis on cocaine and heroin. Some veteran agents, they said, disparagingly referred to meth and other synthetic drugs as "kiddie dope."

In a statement, the DEA called that characterization a "gross misrepresentation" of how its agents view methamphetamine.

The drug agency said it moved in 2000 to tighten scrutiny over companies that sell pseudoephedrine. The DEA said it now requires inspectors to verify customers, check criminal backgrounds and visit the business addresses listed by applicants.

The DEA said it has always accorded a "high priority" to the battle against meth traffickers and the criminals who supply their ingredients. Officials declined The Oregonian's repeated requests to interview DEA Administrator Karen Tandy. However, Terry Woodworth, the agency's deputy director of diversion control, acknowledged last year that the DEA had approved companies it should not have.

"It calls into question the effectiveness of the law, the effectiveness of the regulatory controls, the effectiveness of the regulatory implementation, as well as the effectiveness of the law enforcement," said Woodworth, who has since retired.

"Certainly, we've learned some lessons," he said. "We've made some mistakes."

**Big-money "medicine"**

Congress began cracking down on the chemicals used to make methamphetamine in 1988. Each time new controls were imposed, the traffickers shifted to other chemicals that were unregulated.

By 1995, a combination of U.S. regulations and foreign export controls had shut down the supply of ephedrine, the main ingredient of meth at the time. So Mexican drug cartels, which had pioneered the superlabs in California that churned out 80 percent of the nation's meth, began buying huge quantities of ephedrine's chemical sibling, pseudoephedrine.

While Congress and the DEA slowly worked out a system to regulate pseudoephedrine from 1995 to 1997, imports to the United States surged by 27 percent, according to federal trade statistics. At the same time, sales of cold

medication grew 4 percent. DEA officials think meth traffickers were stockpiling the chemical in anticipation of federal control.

The pills often were made by little-known purveyors of generic vitamins, herbal remedies and over-the-counter medicines on the East Coast. They sold their products to middlemen who supplied knickknacks and candy to gas station mini-marts.

Middle Eastern immigrants in the wholesale trade called their product dawa in Arabic. To their Mexican customers in California, it was la medicina. In any language, "the medicine" meant big money.

The volumes were staggering. Mainstream makers of cold pills sold their product in foil "blister packs" of 30 pills each. Pill companies catering to Mexican cartels packed their pseudoephedrine into bottles that held 120 pills, and the bottles were crammed into crates that held as many as 17,000 pills each.

Court records show that in 1997, at least five little-known companies suspected of supplying the meth trade rivaled the sales of the leading name-brand cold medicine, Sudafed.

But in December 1997, the DEA finally had the authority to control the last remaining aspect of the trade in meth chemicals.

The agency first had gained the authority to turn away imports of ephedrine powder, then the power to approve or reject companies seeking to sell ephedrine tablets. Now, it would decide who could sell pseudoephedrine products.

The meth trade, squeezed by each tightening of the chemical supply, was destined for a crushing blow. But only if the DEA took full advantage of its new powers.

**Flawed enforcement**

At first, the new system seemed to be working as a deterrent.

Mark Reichel, a federal public defender whose clients include drug suspects in Fresno, Calif., said meth cooks ran short of pseudoephedrine.

"There was a big freakout," Reichel said. "They were just doing anything to get their hands on pills."

On the street, federal data show, the purity of methamphetamine began to fall, as did several indicators of meth abuse such as rehab and emergency room admissions.

In California, DEA officials put pressure on businesses that sold pseudoephedrine products, including those produced by Hammer Corp., a major Georgia manufacturer. Hammer's pills had been repeatedly found in California meth labs, according to a federal search warrant affidavit.

California agents pursued multiple criminal cases against some of the distributors. Three other purveyors of Hammer products withdrew their applications for DEA registration after the agency raised questions. By 1998, Hammer's sales were down 75 percent from the year before.

But while the California DEA was turning up the heat, the DEA office in Atlanta, where Hammer was located, granted the company's application to sell pseudoephedrine in April 1998.

"It kind of looks like the right hand doesn't know what the left hand's doing, doesn't it?" said Samantha Spangler, a federal prosecutor in Sacramento who worked on the Hammer case. "I think there may have been that culture of lack of communication in law enforcement between the left coast and the right coast."

Hammer's products continued to show up in the hands of criminals after it was licensed, according to court records. The company eventually pleaded guilty to supplying the meth trade -- its products tied to 71 meth labs, dumpsites, drug suspects and undercover purchases from 1996 through 1999.

Hammer officials did not respond to written questions from The Oregonian.

Beyond inconsistency, DEA's approval process had deeper flaws.

In Newton, N.J., pill-maker Robert Occhifinto applied for a DEA permit in 1997 while serving an 18-month federal prison sentence for laundering $350,000 from ephedrine sales to a California meth maker.

Occhifinto's application was filed on behalf of his company, NVE Pharmaceuticals, which continued operating in his absence. According to the DEA decision published in the Federal Register, the NVE application portrayed Occhifinto's conviction as a failure to file proper paperwork. It also omitted another conviction for smuggling more than a kilogram of hashish from Jamaica, the DEA notice said.

DEA officials took two years to reject Occhifinto's application. But the DEA allowed pending applicants to keep doing business during the review. In that time, Occhifinto's company made 36 sales totaling 3.5 million pseudoephedrine tablets to a customer not registered with the DEA, the agency said.

Occhifinto told a DEA appeals officer that he took steps to ensure his customers were legitimate; in fact, he told the DEA about the sales of 3.5 million pills to the

unregistered customer. But the DEA cited the sale as one of the grounds for rejecting NVE's application, effective December 1999.

**Mountain Express**

The DEA had the power to review records of companies registered to sell pseudoephedrine and ephedrine, but the biggest prosecutions of illegal chemical sales seldom arose from routine audits.

When the DEA shut down suppliers, it frequently came after a massive volume of their products had made their way to meth labs.

The most wide-ranging investigation after the pseudoephedrine law was enacted, for example, was initiated not by the DEA but by an alert security officer at a Federal Express office in Los Angeles.

In September 1999, the officer opened a suspicious box and found thousands of pseudoephedrine pills. When the recipient arrived, the FedEx employee tailed him to his destination and called the DEA, according to an investigator's affidavit filed in federal court.

The package was sent by Hassan Zaghmot, an Aurora, Colo., resident whose application to sell pseudoephedrine was approved by the DEA in July 1998.

After receiving his license, Zaghmot fabricated an elaborate paper trail showing shipments to legitimate customers, according to government testimony. However, it proved unnecessary because the DEA didn't check his records until after the FedEx tip.

The ensuing investigation of Zaghmot, dubbed Operation Mountain Express, revealed a national web of deception. DEA officials said businesses across the country had obtained DEA pseudoephedrine permits to form a 10-man syndicate called "the Commission" with Zaghmot. Its purpose, according to the DEA, was to set black-market prices and coordinate shipments.

By the time the agents shut down the ring in 2000, officials said, the Commission and its customers had moved an estimated 3 metric tons of pills to meth labs -- enough for 36 million doses of meth at street purity.

Mitchel Krause, attorney for a Florida man convicted of illegally selling Zaghmot's and Narog's pseudoephedrine, said the DEA did little more than rubber-stamp the licenses of such wholesalers. He said the wholesalers appreciated that DEA officials were not watching closely.

"I don't know if they looked the other way," Krause said of DEA officials, "or whether they were just negligent in what they did.

"Maybe they didn't think the defendants would figure it out."

**Cultural divide**

The DEA has always been divided on the importance of controlling synthetic drugs and their ingredients.

The job of chemical control fell to civilian employees called diversion investigators. They had no authority to serve warrants, pay informants or claim overtime. Agency veterans say the door-kicking, Mafia-infiltrating special agents of DEA legend held meth in low esteem; they thought even less of unarmed bureaucrats. The funding flowed accordingly.

John Buckley, a retired diversion investigator, recalled watching an old-timer at DEA headquarters weighing the promotion of an agent who had made a career busting amphetamine dealers. "If it ain't heroin," Buckley recalled the reviewer saying, "he ain't getting the grade."

Gene Haislip, head of the DEA's Office of Diversion Control from 1980 to 1997, said he once phoned Florida agents about a 1-ton load of ephedrine powder headed to California by truck.

"You're sending us out to check on some (expletive) powder, when we're up to our ears in cocaine?" Haislip recalled the Florida agents saying. "We don't have time to do that." The load was found only because a New Mexico state trooper happened to stop the truck on a traffic violation.

"They were working heroin, cocaine traffickers, the mob, organized crime, big cases," said Portland agent Debora Podkowa, describing her early contacts with other DEA offices concerning East Coast chemical suppliers. "They looked at what we did in the West as 'kiddie dope.' "

So deeply were these attitudes ingrained, when lawmakers offered money for 100 new chemical investigators and agents in 1989, the Justice Department declined, according to congressional records. Haislip's office warned in 1992 that short staffing would allow for only "minimum fulfillment" of the DEA's responsibility to control the chemical trade.

The agency now spends about $20 million a year -- about 1 percent of its $1.7 billion budget -- to monitor all manufacturers, importers and suppliers of drug precursor chemicals. It deploys 100 people to track 3,000 companies. By comparison, the agency fields more than 4,500 special agents to catch drug dealers.

Internal and external management critiques repeatedly flagged the agency's ambivalence toward chemical control and the role of diversion investigators over

three decades. By the late 1990s, the agency was fighting lawsuits from 250 current and former diversion investigators.

The investigators alleged their bosses routinely called on them to do the same criminal work as special agents, without the benefits or pay.

"The special agents always get the cars and best equipment," said John Coleman, a retired DEA chief of operations and former head of the agency's Boston and Newark, N.J., field divisions. Diversion investigators "are the 9-to-5 crew. They get what's left over."

**"Swimming with sharks"**

While diversion investigators fought internal battles over their proper place within the DEA, the agency faced pressure from the outside to rein them in.

A trade group alleged harassment when a member was subpoenaed for refusing to answer parts of a 34-question DEA application. A mail-order business said the DEA was intruding on its customers' privacy by demanding their names and addresses. The U.S. Small Business Administration warned the DEA that the registration process "could have a tremendous impact" on an important segment of the economy.

Congress proposed in July 1998 to reduce the penalty for failing to report or keep proper records to $500 from $25,000. The Clinton administration assured lawmakers there was no need: The DEA did not plan to punish chemical registrants.

Mary Lee Warren, deputy assistant attorney general, testified that most chemical diversion investigations resulted in "at most, a letter of admonition."

DEA officials were aware of the concerns. From the beginning, they had pushed back the deadline for registering and allowed companies to sell pseudoephedrine while the DEA reviewed their applications. Later, they lowered the registration fee to $116 from a proposed $595. Headquarters officials asked field offices to report monthly how many companies were processed.

In the field, investigators recognized that rejecting a company could create huge delays. Applicants could contest rejections before one of the agency's three administrative law judges, who also heard appeals filed by the nation's 1 million registered doctors and retail pharmacies. Hearings took six months to schedule, and a final decision could take two years.

Diversion investigators experienced in regulating prescription drug sales found themselves confronting an entirely different clientele.

"Now, all of a sudden, we've got some guy operating out of his garage," recalled Detroit investigator Jim Geldhof. "He says, 'I'm handling pseudoephedrine, and I'm going to sell to these gas stations.'

"In a way," Geldhof said, "we were kind of swimming with the sharks with these guys."

Meanwhile, staffing was limited. Agency officials ultimately decided to devote only six hours to investigate each applicant, after initially estimating 14 hours was needed. For follow-up audits, the agency could spare the equivalent of six people to check up on the nation's 3,000 DEA-registered distributors.

"With the volume we were receiving, just a flood of applications in '97, the perceived pressure was on to get them over, get them done," said Marsha R. Jones, a DEA diversion program manager working in Detroit at the time.

**Learning experiences**

Operation Mountain Express, the investigation that began with a tip from FedEx, ended in July 2000 with the arrest of 140 people accused of supplying pseudoephedrine to Mexican drug cartels operating in California. Days later, Attorney General Janet Reno held a news conference to tout it as a DEA success story.

"This operation should send a message," Reno said. ". . . Whether you are a dealer, a manufacturer, or one who makes it all possible by providing the chemical ingredients, you will be held accountable."

Tandy, then a top narcotics attorney under Reno, was livid. She noted that the DEA itself had licensed many of the people charged with supplying pseudoephedrine to meth traffickers. According to people familiar with the case, Tandy posed a steely question to DEA officials afterward.

How, Tandy asked, could you let this happen?

Today, Tandy runs the DEA. President Bush chose her in 2003 to be the first woman to lead the agency, part of the Justice Department.

DEA officials, federal prosecutors and state regulators say Mountain Express made the agency more skeptical of people seeking to sell pseudoephedrine.

Frank Sapienza, a retired DEA chemicals official, said the agency's approach toward applicants used to be "looking at the glass as half full, instead of half empty."

Now companies must show a good reason for selling the product, said Geldhof, the Detroit investigator.

"We really are looking now to say, 'Unless there's a really good basis for it, we're going to deny this thing,' " he said.

The agency said it is doing a better job tracking the sales of the nation's 3,000 registered pseudoephedrine distributors. From 2001 to 2003, the DEA conducted what it called "periodic investigations" of more than 1,300 of those companies.

On average, that meant each company stood a one-in-seven chance of being visited by an inspector each year.

The DEA said it has moved to revoke or deny licenses to 143 companies.

After the Mountain Express case, pseudoephedrine brokers in the United States began looking for a new, unregulated source of pills.

Canada required no license to sell pseudoephedrine. U.S. brokers began hauling pseudoephedrine by the truckload from Quebec to Detroit to Los Angeles. From 1997 to 2001, Canada's legal imports of pseudoephedrine quadrupled to about 140 metric tons.

Under U.S. pressure, Canada responded in 2003 with a DEA-style licensing system for pseudoephedrine dealers.

The haven provided by Canada demonstrated that control over the chemicals needed for meth required more than U.S. regulation. It would also take help from the handful of nations where pseudoephedrine is made.

*News researchers Lynne Palombo and Margie Gultry contributed to this report.*

*Tomorrow: A remedy discovered*

## The flow of chemicals from east to west

The most potent form of methamphetamine can only be made with either ephedrine or pseudoephedrine, chemicals manufactured legally for the pharmaceuticals industry. Only a handful of overseas factories make the chemicals. Of the 1,300 to 1,800 metric tons produced annually, an estimated 200 tons reaches meth cooks in the United States through a variety of channels.

**FOREIGN CHEMICAL MANUFACTURERS SUPPLY DRUG COMPANIES**

Bulk ephedrine and pseudoephedrine powder, which North American drug companies press into pills, comes from nine large-scale overseas factories and roughly 20 small Chinese refiners. Some ephedrine is extracted from Chinese ephedra grass. But most of the world's supply is synthetic, made with a complex biochemical process that involves fermenting molasses.

**U.S. legal imports**

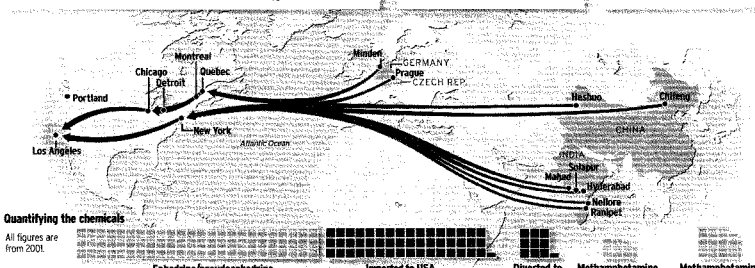
Metric tons of pseudoephedrine and ephedrine powder in 2001.

| | |
|---|---|
| Germany | 392 |
| India | 295 |
| China | 171 |
| Czech Republic | 169 |
| Other | 18 |

**DRUG COMPANIES SUPPLY CARTELS**

The cartels historically have relied on unscrupulous individuals within the U.S. and Canadian pharmaceuticals industry to sell them ephedrine and pseudoephedrine. In many cases, middlemen procured crateloads of the cough and cold pills from wholesalers and small manufacturers, then drove the material to California.

In southern and central California, "superlabs" run by Mexican drug cartels produce an estimated 80 percent of the U.S. meth supply. The cartels, which distribute the drug across the country, require hundreds of tons of the essential ingredients ephedrine and pseudoephedrine.




**Quantifying the chemicals**

All figures are from 2001.

☐ = 25 metric tons



| Ephedrine/pseudoephedrine produced | Imported to USA and Canada | Diverted to meth trade | Methamphetamine made (92% pure) | Methamphetamine sold (50% pure) |
|---|---|---|---|---|
| 1,300-1,800 tons | 1,158-1,212 tons | 183-238 tons | 98-131 tons | 213-285 tons |

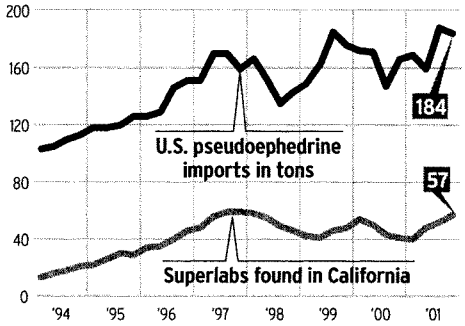
STEVE COWDEN, STEVE SUG/THE OREGONIAN

## PSEUDOEPHEDRINE AND METH LABS

U.S. drug companies import pseudoephedrine for use in cold pills. Massive quantities of those pills end up in superlabs that produce 80 percent of the U.S. meth supply. In the 1990s, when legitimate cold sales were flat and meth production soared, the impact of the illicit market could be seen in quarterly customs statistics.

Note: Each point represents an average of the preceding four quarters of data.

Sources: Western States Information Network; U.S. Census Bureau, Foreign Trade Division




DERRIK QUENZER, STEVE SUO/THE OREGONIAN

# Letter of the law becomes law enforcement by letter

**A DEA program to document dealers of meth chemicals has holes large enough to drive truckloads through**

Tuesday, October 05, 2004

STEVE SUO

The veteran investigators at the U.S. Drug Enforcement Administration found themselves on unfamiliar ground in December 1997, when federal law made them responsible for determining who should be entrusted to distribute pseudoephedrine products.

More than 3,000 companies, many of them self-employed wholesalers who distributed snacks and novelties to mini-marts, lined up seeking DEA licenses. Any company that beat the deadline was allowed to remain in business until the DEA finished reviewing its application, which had to be renewed each year.

Approving the applications was the job of DEA specialists previously assigned to investigating the nation's 1 million doctors, pharmacies and pharmaceutical factories.

With manufacturers, meanwhile, DEA officials needed to develop benchmark sales figures for the industry that might indicate suspicious volumes. There were dozens of generic pill makers to examine in addition to the big-name brands.

The law said inspectors could deny or revoke any type of license if company officials lacked safeguards against illicit sales, broke "applicable" laws, were convicted of a drug felony or didn't have proper experience. The agency also could weigh any other factor it considered "relevant and consistent with public health and safety."

Yet in practice, current and former DEA officials say they were unsure whether such judgment calls would stand up in court if companies challenged them. The preferred alternative was a warning letter.

The following list describes DEA-approved companies whose ephedrine and pseudoephedrine products were discovered in meth labs. Except for Neil Laboratories, none of the companies or their principals were accused of breaking drug laws.

NEIL LABORATORIES INC.

Location: East Windsor, N.J.

Role: Manufacturer

What happened: 3.5 million tablets diverted to the black market; 50 law enforcement actions linked to Neil products in 11 states; four attempts to export millions of tablets to a Tijuana company that submitted bogus import documents.

What the DEA did: In 1998, responding to Neil's repeated attempts to ship to the Mexican customer, the agency rejected Neil's export requests. Yet officials allowed Neil to continue making pseudoephedrine pills for the domestic market -- more than 100 million tablets a year, the DEA now estimates.

The DEA shut down 13 distributors that carried Neil tablets after millions were used in the meth trade. But the manufacturer itself received only warning letters.

In August 2000, officials audited the company's books; later they launched a criminal investigation, sending an informant in May 2001 to tape-record a conversation with the company's part-owner, Mantu Patel.

The outcome: Patel said he had no problem with the informant selling Neil's products to meth makers, according to a federal affidavit. Patel proposed a phony paper trail that would keep the sales under the table, then made two shipments of pseudoephedrine powder to the informant's California business, the affidavit said.

Patel was charged with supplying pseudoephedrine to the meth trade. The felony charge was dropped, and he pleaded guilty this year to a misdemeanor charge involving record-keeping.

In February 2003, the DEA announced that Neil had agreed to stop selling over-the-counter pseudoephedrine products. But the company's Web site advertised ephedrine and pseudoephedrine until September 2003, when The Oregonian asked the DEA's Newark, N.J., office about the ads. They were pulled a few days later.

Company officials did not respond to written questions from The Oregonian.

PDK LABS INC.

Location: Hauppauge, N.Y.

Role: Manufacturer

What happened: Tablets found at 140 meth labs and their dumpsites from 1997 through 2001; four unauthorized shipments of ephedrine from PDK to Canada in 1994 and 1995; thousands of tablets shipped from PDK to mail-order customers, two of them later convicted on meth charges.

What the DEA did: The agency sent the company at least 22 warning letters in four years. In 2000, the DEA halted two 3-ton shipments of ephedrine powder from India on their way to PDK, saying they might be diverted.

The outcome: PDK fought the DEA decision to block the two shipments, arguing that the diversion of its products to meth labs occurred at the retail level, beyond the company's control. For the DEA to block a foreign shipment because it "may" be diverted further down the distribution chain, the company said, is beyond the agency's authority.

An administrative law judge sided with the company, finding no evidence that the number of PDK tablets found in meth labs was unusually high. A federal appeals court this year also sided with PDK, ordering the DEA to reconsider its action.

The appeals court noted that PDK had taken steps to safeguard its products: cutting off distributors suspected of selling products in bulk; ending sales to California or Missouri, states where meth production is high; and hiring a former DEA official to review company policies.

The case continues, and the company remains legally approved to sell ephedrine and pseudoephedrine products.

GEMINI PHARMACEUTICALS INC.

Location: Bohemia, N.Y.

Role: Manufacturer

What happened: About 30 million Gemini pseudoephedrine pills found at 32 labs and dumpsites from 1996 to 1997. Gemini customer Spectrum International convicted of selling more than 350 million pseudoephedrine tablets to the California meth trade from November 1996 through April 1997. Customer Daniel Rosen, who paid Gemini $400,000 for pseudoephedrine from August through December 1997, was convicted of selling millions of pills to the meth trade. Customer Randa Saffo, who bought 40 million Gemini pills, was convicted of supplying the meth trade.

What the DEA did: The agency warned Gemini at least 10 times that its products were used to make meth. The DEA blocked imports of pseudoephedrine destined for Gemini in 1996 because its distributor, Spectrum, was suspected of supplying the black market. Yet officials allowed Gemini to resume imports in 1997 after the company agreed to supply Spectrum's customers directly and cease its California sales.

The outcome: DEA agents searched Gemini's offices in January 1998 but filed no charges against the company. Gemini remains a registered pseudoephedrine seller.

Company officials did not respond to written questions from The Oregonian.

OTC DISTRIBUTION CO.

Location: Dallas, Texas

Role: Wholesaler

What happened: Products found in 20 meth labs and dumps across eight states as of October 2000. Used unlisted 800 numbers on vehicle cell phones and never advertised. Accepted $70,000 cash from one pseudoephedrine customer whose products, it turned out, had been found in meth labs. Sold pseudoephedrine to a customer whose address was a day-care center.

What the DEA did: OTC founder Larry Petit says -- and DEA officials confirm -- that he ran a DEA informant operation at his pseudoephedrine distributorship, L&M Vending, from 1994 to 1997. Petit says he recorded about 100 telephone conversations with shady buyers and arranged dozens of major deals with black marketeers in California and Nevada. He says the DEA recovered more than $1 million in diverted pseudoephedrine because of his efforts.

In 1999, facing death threats from people he had incriminated, Petit was ready to get out of the business. But at the urging of his DEA contacts, Petit says, he formed OTC Distribution to do strictly legitimate sales.

DEA officials allowed it after Petit signed an agreement to go above and beyond the law's record-keeping requirements.

When OTC's products started appearing in meth labs, the DEA sent 14 warning letters. In March 2000, an audit of the company found thousands of bottles unaccounted for.

The outcome: On July 17, 2000, DEA officials suspended the company's license. Investigators ultimately documented sales of 92 million pills by OTC in the first eight months of its registration, rivaling the amount of legitimate cold pills sold by Pfizer, maker of Sudafed, Actifed and Benadryl.

Petit says he feels betrayed by the DEA. The audit of his books was faulty, he says, lumping aspirin in with pseudoephedrine. He says he reported all suspicious sales, and all his customers -- including the day-care center -- were DEA-licensed. Petit says he didn't need to advertise; he had a national list of pseudoephedrine distributors to contact.

DEA officials penalized him, Petit contends, to hide their own incompetence in screening applicants.

"They knew that pseudoephedrine was a problem," Petit said. "They went out and dished out 3,000 licenses. They brought this on themselves."

## The language of meth

Tuesday, October 05, 2004

**The language of America's meth users**

- **Crank, meth, crystal, ice**: Methamphetamine
- **Cooking**: Making meth
- **Spun**: High
- **Spun monkey**: Chronic meth user
- **Slamming**: Injecting
- **Rig**: Hypodermic needle
- **Run**: Multiple days of using meth without sleeping
- **Crash**: Long period of sleep following a run
- **Tweaking**: Going on a long run
- **Tweaker**: Chronic meth user
- **Shadow people**: Image commonly cited by meth users in periods of paranoia

**The language of California meth cops**

- **User lab**: Ounce-quantity lab for a tweaker's personal use
- **Smurfing**: Buying small quantities of pseudoephedrine at many stores, a tweaker practice
- **Real nice lab**: 10-pound (or larger) superlab operated by Mexican cartels in California
- **22**: A 22-liter glass flask, the key component of a superlab
- **Step on it**: Dilute meth with an inactive ingredient
- **Mope**: Migrant farm worker hired to operate a superlab
- **Low crawl**: Police technique to approach a superlab unseen
- **Leg bail**: What mopes do when surprised by low-crawling cops, to flee

**The language of meth traffickers**

- **Chili**: Methamphetamine
- **La medicina**: Mexican trafficker term for pseudoephedrine, from Spanish word for medicine
- **Dawa**: Middle Eastern pill broker term for pseudoephedrine, from Arabic word for medicine
- **Jesus Malverde**: Turn-of-the-century bandit known as the patron saint of Mexican drug traffickers

**Promising fixes to the meth scourge, including a cold pill impervious to abuse, go unpursued as . . .**

## Shelved solutions

Wednesday, October 06, 2004

STEVE SUO

Eight years ago at a laboratory in Texas, Warner-Lambert Co. began testing a possible cure for the methamphetamine epidemic: a new and improved cold medicine that could not be turned into the illicit stimulant.

The company was worried that federal regulators would soon ban or restrict sales of pseudoephedrine, the main ingredient used to make meth and Warner-Lambert products such as Sudafed, Actifed and Benadryl.

Warner-Lambert's meth-proof alternative showed promise in animal testing, conducted at a university lab in Fort Worth. The company quickly applied for a patent. But that is where the product's development ended.

Former company officials said they saw little chance of making a profit on the product. Federal approval of a new drug, which includes lengthy human trials, costs as much as $800 million, according to industry estimates. Warner-Lambert's top-selling cold remedy, Sudafed, was grossing less than $100 million a year.

"It would be a long road and an expensive road," said Robert G. Flynn, a former research vice president at the company.

A cold pill that could not be used to make meth would offer huge public benefits if it replaced existing products. Past constrictions in the flow of meth ingredients have radically altered the trade, disrupting the supply of meth for as long as a year, The Oregonian's analysis of federal data shows.

Federal authorities never offered the pharmaceutical industry financial or other incentives to develop such a pill.

By the time Warner-Lambert had its patent, the threat of a ban on pseudoephedrine had receded. In 2000, Pfizer Inc. took over Warner-Lambert and did not pursue the new cold medicine.

Jay Kosminsky, a Pfizer spokesman, said Warner-Lambert's formula was not enough of an improvement over existing products to merit further research.

Instead, Pfizer tried mixing Sudafed with chemicals that would make it harder for meth traffickers to extract pseudoephedrine. The company chose ingredients

already approved for human use, which made it possible to avoid the lengthy testing required for new drugs.

After seven years of research, the company abandoned that project as unworkable this past summer, Kosminsky said.

Warner-Lambert's new decongestant is a close chemical sibling of pseudoephedrine, the bulk of which is manufactured in nine overseas factories. Executives at two of the largest pseudoephedrine makers -- India's Emmellen Biotech and Malladi Drugs -- say they could supply the new chemical if the vast U.S. market demanded it.

"I can supply large quantities, in tons," said V.N. Gopalakrishnan, technical director at Malladi.

**Fear of a ban**

Pharmaceutical companies have known that cough and cold remedies could be misused ever since the federal government first threatened tighter regulations to deal with the meth problem.

"All manufacturers of these types of products are aware that these decongestant ingredients are related, on a technical, chemical basis, to more powerful abuse drugs," Robert N. Anderson, an attorney for Nyquil maker Richardson-Vicks, wrote to Congress in September 1987.

But Anderson said Vicks' research indicated that it would be impractical for meth cooks to extract ingredients from over-the-counter cold medicine because it "unnecessarily complicates the chemical process, and raises the cost dramatically."

In fact, meth cooks did find it economical to extract the ingredients. The U.S. Drug Enforcement Administration responded in the 1990s with more attempts to control meth ingredients.

James D. Cope, former president of the Consumer HealthCare Products Association, said he warned the trade group's members that the DEA would make pseudoephedrine a controlled substance unless they prevented their products from being misused.

"If you can put some chemical in to make it impossible or almost impossible, that's a way of avoiding the federal sanctions," Cope recalled telling the group, formerly known as the Proprietary Association. "Warner-Lambert was the leader in this."

Warner-Lambert entered a joint venture with Burroughs Wellcome in the mid-1990s to market Burroughs Wellcome's Sudafed and Actifed.

In a 1995 letter to DEA officials, David Long, Warner-Lambert's vice president for regulatory affairs, said it was unlikely the company's products would be used in meth labs. At the same time, Warner-Lambert's scientists were studying how easily meth cooks could extract pseudoephedrine -- and how to counteract that.

Some Warner-Lambert cold medicines combined pseudoephedrine and painkillers with inactive ingredients. In a November 1995 memo to Long, one company scientist explained that it was "rather straightforward" chemistry to dissolve the tablets and obtain pure pseudoephedrine.

Former Warner-Lambert executives say the company, which took over the two Burroughs Wellcome product lines in 1996, wanted to come up with a meth-proof cold medicine in case of a ban.

"The impetus of the research was related to finding decongestants that could not be manipulated," said Flynn, the former research vice president.

"We obviously were well aware of what was going on relative to the methamphetamine issue," said Lester Isbrandt, a former Warner-Lambert research vice president. "We immediately became concerned about it because of its impact on the sale of Sudafed."

Warner-Lambert "had a huge pseudoephedrine franchise," said a source familiar with the research program. "This was an insurance policy."

**The mirror image**

The idea for the new decongestant came from the study of molecules.

Ephedrine, pseudoephedrine and methamphetamine are close molecular cousins; meth, in fact, is ephedrine minus a single oxygen atom.

As a result, their effects on the body are similar. All three shrink blood vessels in the nose and dilate airways in lungs, while unleashing adrenaline that stimulates the heart.

With meth, the latter effect is most pronounced. Removing the oxygen atom, it turns out, makes the molecule fit receptor cells in the human brain "like a key in the lock," said Paul Doering, a professor of pharmacy at the University of Florida.

Each of the three related molecules also has a twin: a mirror image of the same atoms. Flipping the atomic pattern can have a huge effect on how a drug works.

Mirror images can sometimes be even more effective than the original drug, producing the desired outcome with fewer side effects.

Drug companies also introduce mirror images to extend the life of an existing drug with a patent that's close to expiring. For example, AstraZeneca created Nexium, the purple pill that fights indigestion, using a molecular mirror image of its product Prilosec, also marketed in purple.

At Warner-Lambert, a team led by researcher Anthony R. Booth was exploring ways to apply the mirror-image concept to improving the performance of ephedrine, pseudoephedrine and other drug ingredients that affect the central nervous system.

Booth's team came up with a unique insight: Mirror-image pseudoephedrine could only be used to make mirror-image methamphetamine, a benign incarnation of the street drug with few stimulant effects. No amount of processing or lab magic could change that.

And, the new drug appeared to be a better cold medicine.

Warner-Lambert hired a team of researchers at the University of North Texas to test the drug in dogs and rats. The team found the drug remained an effective decongestant but had significantly fewer side effects, such as elevated blood pressure.

The research was complete by December 1997, said Michael Forster, one of the Texas researchers.

"It was essentially devoid of nervous system effects, as far as we could tell," Forster told The Oregonian. "And yet it retained the nasal decongestant effects very well."

**Steep price**

Back at Warner-Lambert headquarters in Morris Plains, N.J., executives discussed what to do next. They filed an initial patent application in July 1998, records show. But they were not sure whether to pursue additional research.

Sudafed was a hugely popular and safe product. Changing the formula would be costly, former executives said.

The U.S. Food and Drug Administration requires three phases of testing on thousands of human subjects. The FDA can impose even more extensive tests for over-the-counter products because consumers use them without a doctor's guidance.

To make the new pseudoephedrine commercially viable, Warner-Lambert executives considered pitching it to the FDA as part of an anti-meth program. If the FDA required companies to sell only mirror-image pseudoephedrine, Warner-Lambert could reap substantial benefits.

"If you had the patent on the only drug that was effective for sinuses, I think it could be lucrative, especially if you had the patent, and everybody else had to come to you," said Isbrandt, the former Warner-Lambert vice president. "That is kind of a pharmaceutical drug researcher's dream."

But the company never made that pitch with Booth's idea.

**Going to Plan B**

While Booth's mirror-image molecule was being tested in Texas, a second team, headed by Warner-Lambert scientist William Bess, went down another avenue.

Bess' team mixed Sudafed with harmless ingredients such as guar gum, a common ice-cream thickener, that would create a sticky mess when meth cooks tried to extract the pseudoephedrine.

On this project, the company worked closely with the DEA.

"We had meetings in Washington," said Isbrandt, "and we would be sending samples back and forth."

Researchers tested the formula using a popular meth recipe found on the Internet. Ordinary Sudafed yielded 89 percent pure pseudoephedrine, but with the additives, no usable pseudoephedrine could be extracted.

Another bonus was that the additives were already FDA-approved chemicals, executives said. Unlike Booth's decongestant, which would be considered a new drug, a cold medicine made with additives would not require costly clinical trials. The company could move the product quickly to market.

Keeping the costs low was important because executives had no guarantees from the government that they would be rewarded for their investment.

"We never had any strong indication coming back from the DEA or other sources saying if we had solved the problem, we would have owned the market," Isbrandt said.

Warner-Lambert applied for a patent on the additives in April 1997. That November, a Warner-Lambert spokeswoman told a British magazine that the company was "now at the final stages of research into a global solution" to the pseudoephedrine problem.

But there was an obstacle. The harder researchers made it for meth cooks to extract pseudoephedrine from Sudafed, the harder it was for digestive fluids to break down the pills and absorb the decongestant.

"We were trying to do a balancing act, to make it difficult for a chemistry lab to get at it, but at the same time make it easy for the body to get at it," Isbrandt said. "We kept trying to get at that sweet spot."

At the same time, the original pressure on Warner-Lambert -- the possibility that regulators might ban pseudoephedrine -- was fading. Industry lobbyists persuaded Congress to exempt from regulation cold products in foil blister packages, which were considered harder for meth cooks to open in volume.

The DEA, which had been a major force behind previous pseudoephedrine rules, stopped pushing for additional powers.

**Research ceases**

The company received patents on both ideas: the additives in October 2000 and Booth's mirror-image pseudoephedrine in December 2002.

Kosminsky, the Pfizer spokesman, said the Booth project ended before the company took over Warner-Lambert in 2000. He said Pfizer gave up on the additives that Bess' team had studied after spending $12 million.

Pfizer plans to introduce a cold medicine in January made with the decongestant phenylephrine, which cannot be converted to meth. Kosminsky said the product will offer consumers an alternative in states that restrict retail sales of pseudoephedrine products.

The company will continue selling Sudafed nationwide.

Today, the National Institute of Drug Abuse spends $1 billion a year, much of it on developing drugs that will fight addiction to substances such as meth.

Yet in the past 15 years, Congress has never seriously debated financing research into a cold remedy that cannot be turned into meth. Pfizer's patent on the mirror-image pill is a public record. Yet lawmakers have never discussed making it easier for Pfizer to get federal approval for its new drug.

Kosminsky said Pfizer would be open to such a proposal.

For now, experts say, drug companies have little incentive to pursue pseudoephedrine alternatives.

"If tomorrow there was no such thing as Sudafed," Doering said, "people would probably be working 24/7 looking for something that could fill that need."

## METH'S PATENTED SOLUTION

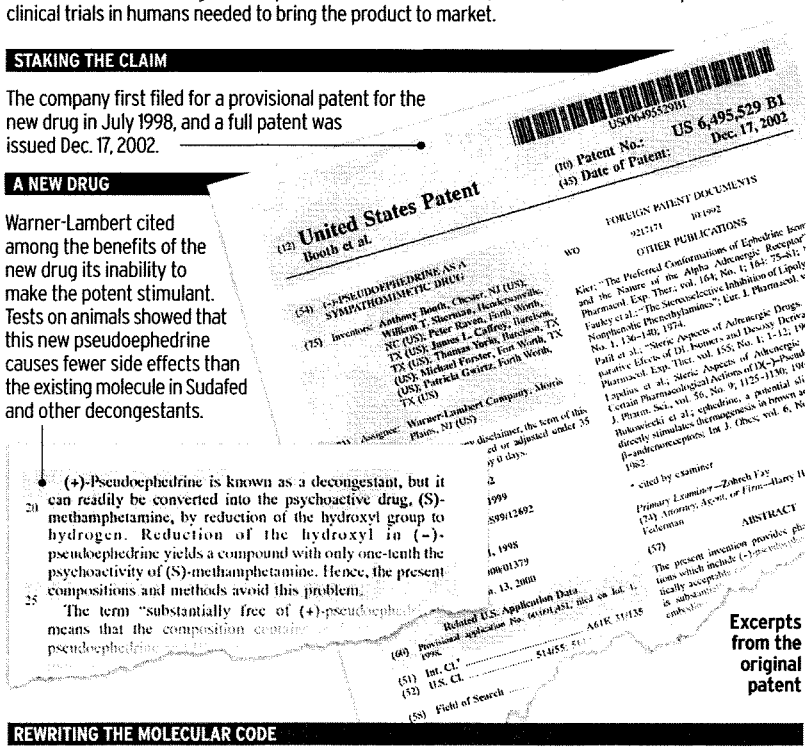
Warner-Lambert Co. and its new owner, Pfizer, hold a patent on an improved cold pill that cannot be made into the street drug methamphetamine. Because of cost, however, Pfizer has not pursued the clinical trials in humans needed to bring the product to market.

### STAKING THE CLAIM

The company first filed for a provisional patent for the new drug in July 1998, and a full patent was issued Dec. 17, 2002.

### A NEW DRUG

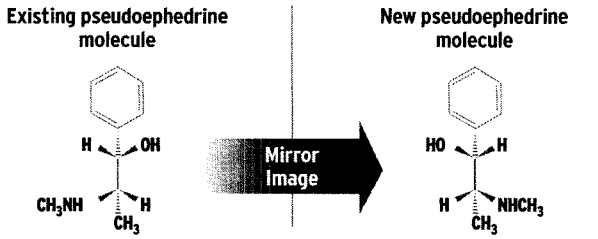
Warner-Lambert cited among the benefits of the new drug its inability to make the potent stimulant. Tests on animals showed that this new pseudoephedrine causes fewer side effects than the existing molecule in Sudafed and other decongestants.




Excerpts from the original patent

### REWRITING THE MOLECULAR CODE

The new pseudoephedrine is a mirror image of the existing molecule. Cooking meth with the new molecule would result in a benign drug with only minor stimulant effects.




DERRIK QUENZER, STEVE SUO/THE OREGONIAN

## Child of the epidemic

**Her mother's addiction to meth, which began before MaKayla Harris' birth, ruptures her family and leaves a void at the heart of a Coos Bay girlhood**

Thursday, October 07, 2004

ERIN HOOVER BARNETT

NORTH BEND - The day her mother vanished again, trading a promising run at sobriety for yet another hit of methamphetamine, 13-year-old MaKayla Harris joined friends at a parking-lot carnival.

She didn't want to think about the magnitude of her mother's fall this time, how close they'd come to reuniting as a family. Mostly, she wanted to forget that this was Mother's Day.

MaKayla remembers scanning the rides. She picked the most frightening: The Zipper. She climbed into one of the steel cages and pulled the padded bar down across her lap. The ride spun like a giant propeller. Her cage whirled and rocked. Beneath her, the coastal community of her childhood blurred.

At first, MaKayla held on, white-knuckled, and screamed. She rode The Zipper more than 15 times that afternoon, coaxing friend after friend aboard with her. Soon, she let her hands hang free.

"At a certain point," she said, "it's not scary anymore."

During MaKayla's lifetime, methamphetamine permeated her hometown on Oregon's southern coast despite concerted efforts by local law enforcement to stop it. Now, in towns and cities throughout the nation, more than 1.3 million people use meth.

MaKayla's 15 years of life span the meth epidemic. Her mother became addicted at its beginning in the late 1980s, and her relapses throughout MaKayla's childhood mimic the rise and fall of the meth trade in the West.

Tens of thousands of children are suffering the consequences. In the worst cases, they endure horrific abuse and die at the hands of their parents. Many more are neglected while their parents get high, too distracted to attend to them. And they shuttle between relatives and foster care, competing for their parents' affection against a cheap and plentiful drug, each time hoping that a child's love will prevail.

It rarely does.

MaKayla's life was filled with broken promises. Over and over, her mother vowed to stay clean, only to retreat to the drug, then to flophouses or jail. MaKayla's little brothers disappeared to foster care -- and emerged in her troubling dreams.

MaKayla found shelter and comfort with her grandparents, Albert and Patricia Muse. Over the years, she persevered by combining a young girl's strong will with a stubborn faith in her mother.

But as she grew older, that faith also threatened to hinder her. Spinning on the carnival ride in the spring of 2003, MaKayla struggled to let go of her hopes for her mother and brace for a future on her own.

**A tenuous childhood**

MaKayla Harris was born Aug. 30, 1989, with big hazel eyes and a squeak for a cry.

Her 27-year-old mother, Debbie Harris, looked down at her firstborn with relief. MaKayla was healthy.

Debbie had become pregnant with MaKayla after more than a year of injecting methamphetamine. She didn't know at the time who the father was. When Debbie was arrested on drug charges five months into the pregnancy, an alarmed child welfare worker made a note in Debbie's file: "We need to gain custody of that child due to her serious meth problem."

But Debbie cleaned up in jail and was released early. She finished out her pregnancy at her parents' aging blue ranch home in North Bend. Debbie was raised in that home. Smart and popular with curling-ironed blond bangs, she used to spend afternoons riding dirt bikes with her friends on the sand dunes nearby.

She married right out of high school, wanting to re-create the stable family life that her millworker father and homemaker mother had made for her and her siblings. But when she was 24, her husband suddenly left.

Debbie recalled seeking solace in local bars. Friends showed her how to tighten her shirt sleeve, jab a needle into a vein and plunge in a hit of meth. Debbie felt a rush of euphoria. Her insecurities slipped away. She felt like superwoman. She was hooked.

Addiction quickly overtook her, and now, Debbie hoped MaKayla's birth would be a turning point. She qualified for welfare and moved with MaKayla from her parents' home into a subsidized apartment.

Yet before long, Debbie left her infant daughter with sitters while she drank at Gussie's Saloon. Early in 1991, Debbie met Morgan Vick there. She was 29. He was a blue-eyed 21-year-old with a mellow swagger. They used cocaine together. She returned to meth.

When MaKayla was 3, Debbie married Morgan while both were jailed -- she for a parole violation, he for drug possession. MaKayla, who had stayed at her grandparents' home, soon moved back with her mom. She remembers a second-story apartment off a main drag in North Bend. It became the scene of a recurring nightmare: MaKayla sees a small child standing in the parking lot below. She looks away from the child and hears an explosion. When she looks again, all that is left are the child's slippers. They are made of ash.

MaKayla does not dwell on haunting images. She tells instead about walking to preschool with her mom, playing board games with her stepfather, or visiting the park with her mom and brother, born in 1994.

By the time she turned 7 in August 1996, MaKayla glimpsed her family's darker side. She saw her stepfather violently shove her mother, pregnant with their second son. The baby was born with meth in his blood. MaKayla remembers moving in 1997 -- for the third time in as many years -- to a cramped apartment near Pony Slough. Debbie had promised authorities she would start over again -- without Morgan. But Morgan returned.

That summer, MaKayla walked in on her parents. She remembers the smell, like cigarette smoke mixed with something spoiled. The odor sharpened near the open bathroom door. She saw her mother and stepfather inside arguing, caught up in the contents of a spoon. They brushed past to let her use the toilet. Her mother looked away.

MaKayla tried her best to cope. She remembers walking her toddler brother down the block for ice cream, holding the little boy's hand, while her parents were strung out in the apartment.

"Half the time, we just ate snacks. There was lots of food. They just didn't fix us meals," MaKayla recalled. "That's when I think it was really bad. They'd sleep for days, get up and go to the bathroom and sleep again.

"They were good parents, when they weren't high."

**Disappointment, devastation**

MaKayla did not stay long at the Pony Slough apartment. She says she was scared by her parents' activities and the rats that scurried around the apartment grounds. She asked her grandparents to take her in again.

Eventually, Morgan beat Debbie bloody in an argument over a meth pipe. Debbie, pregnant again, sobbed as she packed her sons' clothes for foster care. Morgan went to jail for assault; Debbie went to jail, too, for drug possession and child endangerment.

Debbie threw herself into drug treatment, parenting classes and domestic-violence counseling. Supervised by authorities, she got her children back in August 1998. A month later, her third son was born -- healthy.

MaKayla, 9, started fourth grade while Debbie fulfilled her community service work at her oldest son's Head Start program. In early April 1999, a staff person nominated Debbie to be Parent of the Year. "I am working very hard at trying to be the best mom I can possibly be," Debbie wrote in her award application.

Just a few weeks later, as school was letting out, MaKayla was summoned to the office from her classroom. She figured her mother had come to fetch her. Instead, a stranger greeted her.

Get your stuff, MaKayla recalled the stranger saying. You're going to foster care because your mother is in jail.

MaKayla returned, scared and bewildered, to her emptying classroom. Crying, she bundled up her books and told her teacher that she had to go. Friends in the hallway asked her what was wrong. She wouldn't say.

"I didn't want people to think badly of me because of my family," she said.

Debbie served a brief sentence for letting Morgan visit in violation of her probation. When she got out, she started using meth again. MaKayla spent two weeks with her brothers at the foster home, building forts to distract herself. Her grandparents retrieved MaKayla but couldn't handle all four children. Her brothers stayed behind.

MaKayla's grandparents tried to raise her spirits. That summer, MaKayla's grandfather got out his old record albums and taught her to do the twist.

"He's what held me together," MaKayla recalled.

Days later, on the first morning of fifth grade, she awoke to commotion. Her grandfather had died of a heart attack in the night. MaKayla remembers how still he was in his casket. But she had no final words for him. All she could do was cry.

His death galvanized Debbie. She weaned herself from drugs and was reunited again with her four children in April 2000. For a time, life seemed to stabilize. She

resumed her relationship with Morgan, who worked as a logger. They grilled steaks outside while MaKayla and her brothers played in the yard.

In early March 2001, when MaKayla was 11, she noticed that her mother seemed distracted, unfocused. Sitting at their kitchen table, MaKayla asked if she was using drugs again. Debbie denied it.

But, in the pre-dawn hours of March 29, police found Debbie passed out in her van at The Mill Casino. She was nearly dead from a meth overdose.

MaKayla visited Debbie in jail. She remembers her message to her mother that day: You lied to me. And I could've helped you.

**A prayer for renewal**

MaKayla stood outside the North Bend Middle School cafeteria, surrounded by a half-dozen other girls, and plotted their lunchtime mission one December day in 2002.

Now an eighth-grader, MaKayla had learned to take charge. She occupied the center of a large social web at this timeworn middle school. She pulled her long, honey-brown hair up in a loose bun and decorated her sweatshirts and hip-huggers with safety pins. Other girls followed her lead, attracted to MaKayla's individuality.

At 13, MaKayla thrived on their attention. She survived her mother's overdose with roller-skating parties, sleepovers and church youth-group outings. She decorated her mother's old bedroom at her grandma's house with snapshots of classmates and posters of pop rockers.

But sometimes her sadness welled up. She cried watching "A Christmas Carol." Tiny Tim reminded her of her little blond brothers, who were in foster care.

MaKayla missed them. She had not seen the boys since the spring, when Debbie got out of jail, and a judge terminated her parental rights. Debbie filed an appeal to get the boys back. She was attending treatment support groups and living with a friend from her church.

"With God as my witness, you'll never see me in court again for drugs," Debbie wrote to the judge. "My children are everything to me."

MaKayla prayed that this time her mother would succeed.

On Dec. 10, MaKayla arrived to baby-sit at her mom's church-sponsored treatment group. She noticed her stepfather, just out of prison, walk in with a friend from his drug-using days. MaKayla knew that if her stepfather relapsed,

her mother might follow. She found her mother alone, crying, in the cold parking lot.

Debbie remembers the fear in her daughter's hazel eyes.

Honey, she recalls telling her, I will not go back.

Oh, Mama, MaKayla pleaded, promise?

At an age when many kids rebuff their parents' attention, MaKayla was renewing her crucial place in her mother's life. Debbie told her she would come over with Morgan on Dec. 16.

At dinnertime, MaKayla set up folding tables, too heavy for her grandma to carry. Patricia, 61, sat in her recliner, weak after multiple heart attacks and a stroke.

MaKayla came over and sat in her grandpa's old recliner. She dipped her chicken strips in ranch dressing. She guessed at the "Jeopardy" clues on television. The evening wore on with no sign of Debbie and Morgan.

Finally, MaKayla's grandma said gently, "Looks like they're not coming, Sis."

MaKayla stared at the television. If she heard her grandma, she didn't show it.

**An addict's guilt**

The next evening, MaKayla backed out of her plans to baby-sit at her parents' treatment support group. Debbie and Morgan, not realizing they had let her down the night before, were frustrated.

Morgan, blue eyes melancholy beneath his prison-shaved head, said he had been looking forward to seeing MaKayla. He said he just wanted another chance with the kids.

"Even though we were high, we never abused them physically. Mentally -- I guess there was mental abuse," he said. "It was really sad."

Debbie sat beside Morgan at the support group in a chilly church basement, their arms touching. When it was Debbie's turn to speak, she described the force that lures her back to meth.

"I have a lot of guilt," Debbie said. "I sit and think about the kids and stuff, and it's really hard. Until you've done what I've done, I guess you really can't understand that type of guilt."

Over the winter, Debbie saw MaKayla sporadically. She and Morgan were living with their pastor, Ivan Sharp. Sharp was trying to help them rebuild. But Morgan was drinking again. He and Debbie were fighting, and she feared a relapse. She was impressed by a couple who invited her and Morgan for dinner. The couple's toddler ate off a glass plate without breaking it. The parents spoke respectfully to their kids.

Debbie recognized a simple truth about MaKayla: "All she ever wanted from me was to stop using drugs. I look at my daughter -- what a blessing. Why couldn't I appreciate that? Why couldn't that have been enough?"

Debbie landed a greeter's job at a discount grocery store. She quickly took over a check stand. "Deborah," the store owner wrote on her first paycheck, "we are so pleased to have you with us."

"I could have that," Debbie said. "There was such a bond between me and my children even though I was an addict. But the emotional part wasn't there."

The state garnished Debbie's wages by $146 a month to help support MaKayla. Debbie bought her daughter a Valentine's Day gift -- a box of chocolates and a stuffed skunk holding a rose.

"Not much," Debbie said. "But she knows I love her."

**The end of childhood**

MaKayla headed into Wal-Mart in search of poster board for a school assignment in late March 2003. She passed a large display of Easter baskets, just like the ones she and her mom had given her brothers on their last visit before the state permanently severed Debbie's parental rights to them.

MaKayla said being in the store reminded her of a dream: She is shopping and encounters her brothers in one of the aisles. They don't recognize her.

But MaKayla shrugged and said she thought her mother was ready to reunite their family. After all, she was winning awards at work for good customer service and balancing her till. She had left Morgan again and moved in with a friend. "She's slowly getting better," MaKayla said. "She just needs to get a house."

On Easter, the anniversary of losing the boys, Debbie visited MaKayla. They sat together on the bed in Debbie's old room. She gave MaKayla an Easter gift. She remembers asking MaKayla if this day was hard for her. MaKayla hesitated and then looked intently at her mom. She admitted that it was.

You don't have to be so tough, Debbie told MaKayla. It's OK to cry.

No, it's not, MaKayla answered.

Debbie struggled to reassure MaKayla. Mama's trying, she told MaKayla. I'm really trying to make things right.

Three weeks later, Debbie was gone.

Early on the Saturday morning before Mother's Day, she showed up at the friend's apartment where she had been staying. Her blond hair was disheveled. She was limping. The friend knew that Debbie had started hanging out with a meth dealer. That morning, she said she asked Debbie to move out.

The friend called to tell MaKayla's grandma that Debbie had left. When Debbie didn't visit on Mother's Day, MaKayla knew in her heart that she had returned to using meth. MaKayla went with her friends to the parking-lot carnival and rode The Zipper, her dreams of reuniting with her mom and brothers spinning away.

MaKayla heard only secondhand reports about her mother in the following weeks. MaKayla's child welfare caseworker learned that Debbie had relapsed. He told MaKayla and her grandma that MaKayla should not ever plan to live with Debbie again. MaKayla's aunt and uncle agreed to take her in if anything happened to her grandma. With those plans in place, he told MaKayla, she had reached an age where the state would no longer closely monitor her case.

On her last day at North Bend Middle School in June, MaKayla spent the lunch hour licking ice cream bars with her friends in the warm stillness of a deserted hallway. For a while, it was as if she could remain suspended in childhood forever.

But after two more classes, the final bell sounded. Several students whooped, but MaKayla didn't react. She followed the wave of kids out of the classroom. She milled around in the throng, moving toward the exit. She hugged friends as they passed. Tears welled in her eyes.

The school doors swung open. The afternoon light poured in. MaKayla walked out into the glare.

**Drifting**

MaKayla sat on the mottled brown carpet at a girlfriend's apartment, music videos playing on the television, and listened to three of her friends talk about dieting, school and boys. She made a bracelet out of black electrical tape and jumped in when the conversation interested her.

More than a year had passed since she walked out the doors of her middle school. MaKayla was nearly 15 now. Her hair was shorter and softly layered, a

more mature look. She had dyed it black underneath, still inventing her own styles.

MaKayla had spent the summer after eighth grade wondering where her mother was. The day after her 14th birthday, Aug. 30, 2003, MaKayla heard the front door open. In walked her mom. MaKayla ran to hug her. Debbie apologized.

Debbie later said she had turned back to meth to escape her creeping fear that she would lose the appeal for her sons. In fact, she did lose the appeal, but MaKayla's only inkling was a letter that came to her grandma's house from her mother's attorney. It sat unopened all summer next to her grandma's recliner.

MaKayla was relieved to see her mother, but said she also felt scared that Debbie "would just go out and never talk to me again."

So that fall, MaKayla tried to concentrate instead on her freshman year. Her grandma took her to pick out a black off-the-shoulder dress for her first homecoming dance. She got C's in science and English but otherwise pulled A's and B's. She wrote down goals in the workbook for her favorite class, the psychology of success: Go to college. Become a forensic scientist. Travel.

In her locker, she stuck an old photograph of her mom, vibrant in a Harley-Davidson jacket, the way she looks when she's not using meth. In her workbook, MaKayla recorded a wish: "My brothers would live with me."

She also wrote about a deepening sense of powerlessness, about times when her eyes water, her body shakes, and "I can't think straight . . . everything runs through my mind."

Midway through the school year, MaKayla's focus blurred.

She spent evenings e-mailing friends rather than doing homework. Her mother began showing up more often after another jail term in February. Together, they sorted through MaKayla's brothers' baby clothes and held a garage sale. Meanwhile, MaKayla's relationship with her grandma frayed for a time as MaKayla pushed the rules, and her grandma wearied of pushing back.

In April, North Bend police caught MaKayla and several friends smoking pot in the woods near MaKayla's home. MaKayla appeared before Judge Richard Barron, the same Coos County judge who had terminated her mother's rights to the boys after one too many promises of reform. He lectured MaKayla and suspended her driving privileges.

MaKayla later said she smoked the marijuana because, "I thought everything was bad. Bad life. Bad everything." After doing it, she felt remorse. She said she would "definitely not" try pot again and has no intention of ever trying meth.

But her second term at school had already suffered. She failed English and science. She tried to make up the classes over the summer but didn't finish them. Instead, she hung out with her friends or stayed with her mom on a logging site where Debbie and Morgan lived in a trailer, and Debbie was paid to mind the equipment.

MaKayla considered moving in with her mother. She also thought about living with her 15-year-old friend, Monica Taylor, who has a subsidized apartment with her 9-month-old baby.

Sitting in Monica's living room in August, MaKayla and her girlfriends were talking about their upcoming sophomore year when the subject shifted.

"Are you going out with Kris?" asked Victoria Hunter, 15, referring to MaKayla's first significant boyfriend. "That's so cute."

Monica, cuddling her baby on her lap, interjected, pinpointing the moment that Kris first kissed MaKayla. "They started going out exactly at 3 o'clock at my house."

MaKayla reclined on the arm of the couch, the red Converse tennis shoes she'd decorated with marker kicked out in front of her.

She didn't say anything. She just pulled the tie from her hooded sweatshirt through her teeth and smiled.

Erin Hoover Barnett: 503-294-5011; ehbarnett@news.oregonian.com

## Editor's Note

Thursday, October 07, 2004

Coos County corrections authorities recommended Debbie Vick to reporter Erin Hoover Barnett in November 2002 as a recovering meth addict.

Debbie agreed to share her story, as did her daughter, MaKayla, then 13; her mother, Patricia Muse; and Debbie's husband, Morgan Vick.

To help build the family's chronology, Debbie, with MaKayla's knowledge, gave Barnett their two-volume file of child welfare and police reports. Barnett and photographer Fredrick D. Joe visited the family regularly from December 2002 through August 2004.

Story scenes that Barnett did not witness are told instead through the memory of those present. Barnett reviewed her reporting with the family at various points to check for accuracy and prepare them for its content. She contacted child welfare officials to alert Debbie's sons' foster family about the story and talked with

MaKayla's high school principal. Despite drug relapses, Debbie continued to support the project, as did MaKayla.

"Hopefully, the whole story will help people," MaKayla said.

MaKayla turned 15 on Aug. 30 and started her sophomore year Sept. 8 at North Bend High School. Her mother missed her birthday again, as well as a back-to-school shopping trip. MaKayla's grandmother took her instead.

318

# Iowa Adult Pseudoephedrine Products Purchasing Survey

Prepared by the
Center for Social and Behavioral Research
University of Northern Iowa

Gene M. Lutz
Jaime Mayfield

October 2003

# Table of Contents

**Page**

**List of Figures** ..... **i**

**List of Tables** ..... **ii**

**Purpose & Methodology** ..... **1**

Purpose ..... 1

Methodology ..... 1

Sampling Plan ..... 1
Data Collection ..... 2
Analysis ..... 2

**Description of the Sample** ..... **3**

**Main Findings** ..... **5**

Purchase of Medications Containing Pseudoephedrine ..... 5

Location, Quantity, and Frequency of Medication Purchases ..... 11

Heard of Using Pseudoephedrine to Manufacture Methamphetamine? ..... 15

Is the Manufacture of Meth Using Pseudoephedrine a Problem? ..... 16

Attitudes Toward Purchasing Restrictions ..... 17

**Summary** ..... **27**

**Appendices:** ..... **29**

A-1 Frequencies by Gender and Age Group ..... 31

A-2 Frequencies by Education Level and County Type ..... 38

# List of Figures

Figure 1: Number of Completed Interviews by County ....1
Figure 2: Gender ....3
Figure 3: Age Group ....3
Figure 4: Education Level ....4
Figure 5: County Type ....4
Figure 6: Household Purchased Any Non-prescription Medications ....5
Figure 7: Purchased Cold or Sinus Products ....6
Figure 8: Purchased Cold or Flu Products ....7
Figure 9: Purchased Allergy Products ....8
Figure 10: Purchased Any Other Products ....9
Figure 11: Household Purchased at Least One of these Medications ....10
Figure 12: Place Medications were Purchased ....11
Figure 13: Amount of Medications Purchased ....13
Figure 14: Frequency of Medications Purchased ....14
Figure 15: Heard of Pseudoephedrine to Manufacture Meth ....15
Figure 16: Problem of Meth Using Pseudoephedrine ....16
Figure 17: Inconvenience of Limiting Quantity of Medications Purchased ....17
Figure 18: Inconvenience of Showing Photo-ID to Purchase the Medications ....18
Figure 19: Inconvenience of Asking Pharmacist/clerk for the Medications ....19
Figure 20: Effectiveness of Limiting Quantity of Medications Purchased ....20
Figure 21: Effectiveness of Showing Photo-ID to Purchase the Medications ....21
Figure 22: Effectiveness of Asking Pharmacist/clerk for the Medications ....22
Figure 23: Support for Limiting Quantity of Medications Purchased ....23
Figure 24: Support for Showing Photo-ID to Purchase the Medications ....24
Figure 25: Support for Asking Pharmacist/clerk for the Medications ....25
Figure 26: Summary of Public Views ....28

# List of Tables

Table 1: Call Disposition Record....2
Table 2: Sample Characteristics....3
Table 3: Household Purchase by Demographics....5
Table 4: Purchased Cold or Sinus Products by Demographics....6
Table 5: Purchased Cold or Flu Products by Demographics....7
Table 6: Purchased Allergy Products by Demographics....8
Table 7: Purchased Any Other Products By Demographics....9
Table 8: Household Purchased at Least One Medication by Demographics....10
Table 9: Place Medications were Purchased by Demographics....12
Table 10: Amount of Medications Purchased by Demographics....13
Table 11: Frequency of Medications Purchased by Demographics....14
Table 12: Heard of Pseudoephedrine to Manufacture Meth by Demographics....15
Table 13: Problem of Meth Using Pseudoephedrine by Demographics....16
Table 14: Inconvenience of Limiting Quantity of Medications Purchased by Demographics....17
Table 15: Inconvenience of Showing Photo-ID to Purchase the Medications by Demographics....18
Table 16: Inconvenience of Asking Pharmacist/clerk for the Medications by Demographics....19
Table 17: Effectiveness of Limiting Quantity of Medications Purchased by Demographics....20
Table 18: Effectiveness of Showing Photo-ID to Purchase the Medications by Demographics....21
Table 19: Effectiveness of Asking Pharmacist/clerk for the Medications by Demographics....22
Table 20: Support for Limiting Quantity of Medications Purchased by Demographics....23
Table 21: Support for Showing Photo-ID to Purchase the Medications by Demographics....24
Table 22: Support for Asking Pharmacist/clerk for the Medications by Demographics....25
Table A-1: Frequencies of Categorical Variables by Gender and Age Group....31
Table A-2: Frequencies of Categorical Variables by Education Level and County Type....38

# Purpose & Methodology

## *Purpose*

The State of Iowa Governor's Office of Drug Control Policy (ODCP) contracted with the Center for Social and Behavioral Research (CSBR), University of Northern Iowa, to conduct a public survey focused on purchases of over-the-counter medications containing the ingredient pseudoephedrine. The primary purpose was to estimate public views of possible changes in the conditions for making such purchases. As has happened in other states such as North Dakota and Missouri, Iowa officials are considering the potential impact that changing purchasing regulations might have on the use of pseudoephedrine products in the illegal manufacture of methamphetamines.

## *Methodology*

**Sampling Plan.**

The population frame consisted of all adult Iowans living in private (non-institutionalized) residences and having land-line telephones. A random digit sample of telephone numbers statewide (without geographic stratification) likely to be assigned to private residences was drawn by Survey Sampling, Inc. CSBR interviewers hand dialed these numbers to determine whether each was actually attached to a private residence. If so, the study was introduced and the adult with the most recent birthday was invited to be a study respondent. The goal was to conduct 400 interviews; 410 were completed. The distribution of completed interviews by county was well-matched with the actual distribution of households.

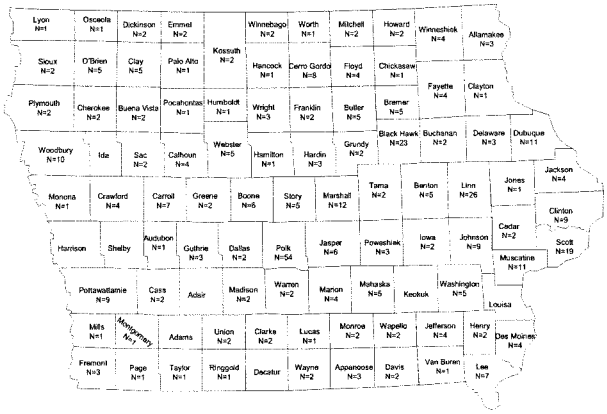



**Figure 1. Number of Completed Interviews by County**

**Data Collection.**

Data were collected between August 5 and August 28, 2003, via Computer Assisted Telephone Interviewing (CATI) at the Center for Social and Behavioral Research, University of Northern Iowa. A total of 2340 random telephone numbers were attempted for the study. A minimum of 6 attempts were made to contact each selected household and/or selected respondent before abandoning the number. Using American Association for Public Opinion Research standard definitions for call outcome rates (http://www.aapor.org/default.asp?page=survey_methods/response_rate_calculator) yielded the following: cooperation rate: 72%; refusal rate: 12%; and response rate: 31%.

**Table 1**
**Call Disposition Record**

| | |
|---|---|
| Completions | 410 |
| Refusals | 163 |
| Unable to Communicate | 36 |
| Not eligible | 1087 |
| Unknown | 644 |
| Total attempted | 2340 |

**Analysis.**

Data were examined for each question as a whole and by demographic subgroups for gender, age group, education level and county type. Counties were categorized based on the population size of the largest place within the county: rural (largest place less than 2,500), mostly rural (largest place 2,500 – 6,999), mostly urban (largest place 7,000 – 49,999), and urban (largest place 50,000 or more). The more important statistically significant differences (at the .05 level) among demographic subgroups are noted in the tables and discussed in the findings. Percentages shown in tables and figures may add to more than 100% due to rounding.

Findings based on the total sample of 410 cases are estimated to have sampling errors at the 95% confidence level of approximately +/- 5%. Findings based on demographic subgroups will have larger sampling errors due to the smaller number of cases within each of those subgroups.

# Description of the Sample

The demographic characteristics of the sample and total Iowa adult population by gender, age group, education level, and county type are shown below.

**Table 2**
**Sample Characteristics**

| Demographics | Sample | Population |
|---|---|---|
| **Total** | **410** | **2,238,715** |
| **Gender** | **%** | **%** |
| Men | 35.4 | 48.4 |
| Women | 64.6 | 51.6 |
| **Age Group** | | |
| 18-24 | 8.9 | 14.1 |
| 25-34 | 13.3 | 16.2 |
| 35-44 | 16.8 | 19.3 |
| 45-54 | 18.0 | 18.7 |
| 55-64 | 15.8 | 12.4 |
| 65-74 | 14.6 | 9.1 |
| 75+ | 12.6 | 10.2 |
| **Education Level** | | |
| Elementary | 3.7 | 5.6 |
| Some High School | 5.1 | 8.3 |
| High School Graduate | 32.6 | 36.1 |
| Some College or Technical School | 28.7 | 28.8 |
| College graduate | 21.6 | 14.7 |
| MA degree | 8.3 | 6.5 |
| **County Type** | | |
| Rural | 6.3 | 6.2 |
| Mostly rural | 20.2 | 20.6 |
| Mostly urban | 32.9 | 27.8 |
| Urban | 40.5 | 45.5 |

Note. Population characteristics of Iowa adults are based on the 2002 census estimates, except for education level which is based on the 2000 census.

The sample consisted of 35% men and 65% women. Compared to the population, the sample contained more women and fewer men.

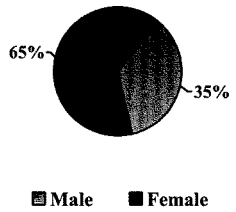



**Figure 2. Gender**

The mean age of the respondents was 51 years, with a median value of 52. The sample was slightly older than the adult population.

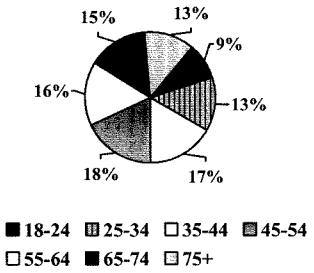



**Figure 3. Age Group**

The distribution of the sample's education level (highest grade or year of school completed) was only slightly higher overall than for all Iowa adults. Nine percent of respondents had less than a high school education, one-third (33%) had a high school diploma or GED, more than one-fourth (29%) had completed some college or technical school, slightly less than one-fourth (22%) were college graduates, and 8% had a graduate degree.

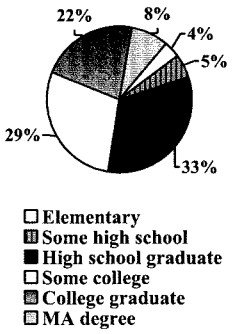



Figure 4. Education Level

Rural county residents made up 6% of the sample. One-fifth (20%) of respondents were from mostly rural counties, one-third (33%) of respondents were from mostly urban counties, and slightly more than two-fifths (41%) were from urban counties. This compared closely to Iowa overall.

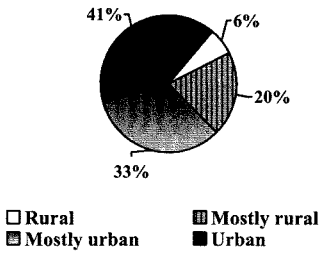



Figure 5. County Type

# Main Findings

### *Purchase of Medications Containing Pseudoephedrine*

**Q1:** In the past year, has anyone in your household purchased any non-prescription medications for nasal decongestion, colds, flu or allergies?

In response to an introductory **general purchasing** question (Q1) about one-half (54%) of the respondents reported that someone in their household purchased a non-prescription medication for nasal decongestion, colds, flu, or allergies in the past year.

Significant differences were found among different age groups and education levels. With the exception of 18-24 year olds, as age increased, the percent of household purchases of pseudoephedrine-containing medications decreased. Nearly three-fourths of 25-44 year olds reported that someone in their household purchased the medications while roughly one-third of those 65 and older reported such household purchases.

Respondents with higher levels of education reported comparatively more household purchases of these non-prescription medications.

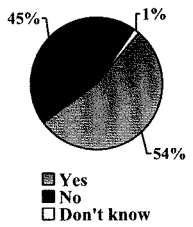



**Figure 6. Household Purchased Any Non-prescription Medications**

**Table 3**
**Household Purchase by Demographics (%)**

| Demographics | Yes | No | DK |
|---|---|---|---|
| **Total** | **53.9** | **44.6** | **1.5** |
| **Gender** | | | |
| Men | 51.0 | 46.2 | 2.8 |
| Women | 55.5 | 43.8 | 0.8 |
| **Age Group*** | | | |
| 18-24 | 50.0 | 41.7 | 8.3 |
| 25-34 | 74.1 | 24.1 | 1.9 |
| 35-44 | 73.5 | 26.5 | 0 |
| 45-54 | 60.3 | 39.7 | 0 |
| 55-64 | 46.9 | 51.6 | 1.6 |
| 65-74 | 35.6 | 64.4 | 0 |
| 75+ | 33.3 | 64.7 | 2.0 |
| **Education Level*** | | | |
| High school or less | 42.6 | 56.8 | 0.6 |
| 1-3 yrs of college | 60.7 | 36.8 | 2.6 |
| BA or MA degree | 63.9 | 35.2 | 0.8 |
| **County Type** | | | |
| Rural | 34.6 | 61.5 | 3.8 |
| Mostly rural | 53.0 | 45.8 | 1.2 |
| Mostly urban | 53.3 | 45.9 | 0.7 |
| Urban | 57.8 | 40.4 | 1.8 |

*Significant at $p < .05$.

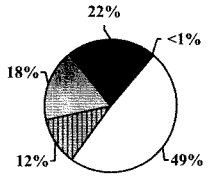
**Q2a:** In the past year, have you or anyone in your household purchased any cold and sinus products such as Actifed, Advil, Alka-Seltzer, Aleve, Cepacol, Comtrex, Contac, Dristan, Sine-Off, Sudafed, or Tylenol?

Following the very general purchasing question (Q1), respondents were asked more specifically about purchasing types of products that usually contain pseudoephedrine. Nearly one-half (49%) of the respondents purchased a **cold or sinus product** themselves in the past year. Twelve percent reported that someone else in the household purchased these medications, 18% reported that both the respondent and someone else in the household purchased them, 22% reported no purchases of these medications, and less than 1% said they did not know.

A higher percentage of women than men reported purchasing by the respondent only (57% vs. 35%) and no household purchasing (23% vs. 20%). Men reported higher rates than women of purchasing by someone else in the household (21% vs. 6%) and by both the respondent and someone else in the household (24% vs. 14%).

People 25 and older reported purchasing cold and sinus products more so than did the youngest adults.

Those with the least education tended to purchase these products at a lower rate than the more highly educated.




- Yes, Respondent Purchased
- Yes, Someone Else Purchased
- Yes, Both Purchased
- No One Purchased
- Don't know

**Figure 7. Purchased Cold or Sinus Products**

**Table 4**
**Purchased Cold or Sinus Products by Demographics (%)**

| Demographics | Yes, Respondent Purchd | Yes, Someone Else Purchd | Yes, Both Purchd | No One Purchd | DK |
|---|---|---|---|---|---|
| **Total** | **48.8** | **11.7** | **17.6** | **21.7** | **0.2** |
| **Gender*** | | | | | |
| Men | 34.5 | 21.4 | 24.1 | 20.0 | 0 |
| Women | 56.6 | 6.4 | 14.0 | 22.6 | 0.4 |
| **Age Group*** | | | | | |
| 18-24 | 19.4 | 27.8 | 33.3 | 19.4 | 0 |
| 25-34 | 55.6 | 5.6 | 27.8 | 11.1 | 0 |
| 35-44 | 60.3 | 10.3 | 14.7 | 14.7 | 0 |
| 45-54 | 56.2 | 16.4 | 12.3 | 15.1 | 0 |
| 55-64 | 39.1 | 9.4 | 25.0 | 25.0 | 1.6 |
| 65-74 | 47.5 | 13.6 | 11.9 | 27.1 | 0 |
| 75+ | 49.0 | 3.9 | 5.9 | 41.2 | 0 |
| **Education Level*** | | | | | |
| High school or less | 45.6 | 11.8 | 12.4 | 30.2 | 0 |
| 1-3 yrs of college | 52.1 | 12.8 | 16.2 | 18.8 | 0 |
| BA or MA degree | 50.0 | 10.7 | 26.2 | 12.3 | 0.8 |
| **County Type** | | | | | |
| Rural | 46.2 | 23.1 | 7.7 | 23.1 | 0 |
| Mostly rural | 44.6 | 12.0 | 15.7 | 27.7 | 0 |
| Mostly urban | 55.6 | 11.1 | 14.8 | 18.5 | 0 |
| Urban | 45.8 | 10.2 | 22.3 | 21.1 | 0.6 |

*Significant at $p < .05$

**Q2b:** In the past year, have you or anyone in your household purchased any cold and flu products such as Comtrex, TheraFlu, Robitussin, or Vicks?

In about two-thirds of respondent households (62%) no one had purchased any **cold and flu products** in the past year. About one-fourth of respondents (24%) had purchased the products themselves. Five percent reported that only someone else in the household purchased the products, 8% reported that both respondent and someone else purchased the products, and 1% said they did not know.

A higher percentage of women than men (28% vs. 18%) purchased the products themselves, and a higher percentage of men than women (12% vs. 5%) reported that both the respondent and someone else in the household purchased these medications.

Households with respondents aged 45 and older had higher percentages with no household purchases of cold and flu products than those with younger respondents.

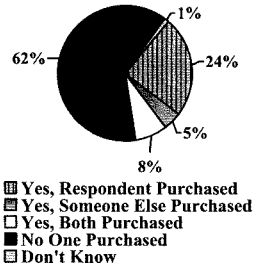



**Figure 8. Purchased Cold or Flu Products**

**Table 5**
**Purchased Cold or Flu Products by Demographics (%)**

| Demographics | Yes, Resp Purchd | Yes, Someone Else Purchd | Yes, Both Purchd | No One Purchd | DK |
|---|---|---|---|---|---|
| **Total** | **24.1** | **4.6** | **7.6** | **62.7** | **1.0** |
| **Gender*** | | | | | |
| Men | 17.9 | 6.9 | 12.4 | 62.1 | 0.7 |
| Women | 27.5 | 3.4 | 4.9 | 63.0 | 1.1 |
| **Age Group*** | | | | | |
| 18-24 | 8.3 | 13.9 | 19.4 | 55.6 | 2.8 |
| 25-34 | 25.9 | 1.9 | 16.7 | 55.6 | 0 |
| 35-44 | 41.2 | 7.4 | 5.9 | 45.6 | 0 |
| 45-54 | 19.2 | 6.8 | 4.1 | 68.5 | 1.4 |
| 55-64 | 14.1 | 0 | 9.4 | 73.4 | 3.1 |
| 65-74 | 25.4 | 3.4 | 3.4 | 67.8 | 0 |
| 75+ | 27.5 | 2.0 | 0 | 70.6 | 0 |
| **Education Level*** | | | | | |
| High school or less | 26.0 | 4.7 | 4.1 | 65.1 | 0 |
| 1-3 yrs of college | 25.6 | 6.8 | 9.4 | 58.1 | 0 |
| BA or MA degree | 19.7 | 2.5 | 10.7 | 63.9 | 3.3 |
| **County Type** | | | | | |
| Rural | 23.1 | 15.4 | 3.8 | 57.7 | 0 |
| Mostly rural | 24.1 | 6.0 | 8.4 | 60.2 | 1.2 |
| Mostly urban | 23.7 | 3.7 | 6.7 | 65.2 | 0.7 |
| Urban | 24.7 | 3.0 | 8.4 | 62.7 | 1.2 |

*Significant at $p < .05$.

**Q2c:** In the past year, have you or anyone in your household purchased any allergy products such as Benadryl, Chlor-Trimeton, Drixoral, Sine-Off, Sineutab, or Triaminic?

The majority of respondent households (62%) had not purchased any **allergy products** in the past year. One-fourth of respondents (25%) have purchased these products themselves, 6% reported that someone else in the household had purchased the products, 7% reported that both respondent and someone else had purchased the products, and less than 1% said they did not know.

More women (30%) purchased the products themselves than had men (15%). More men than women reported that someone else in the household and that both respondent and someone else had purchased the allergy products.

Respondent purchasing of allergy products was highest among 25-34 year olds (33%) and 35-44 year olds (40%). Over two-thirds of those 55 and older reported no household purchase of any allergy products.

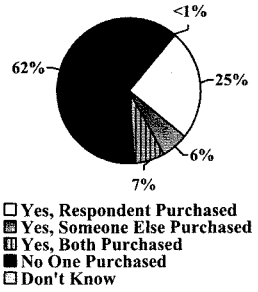



**Figure 9. Purchased Allergy Products**

**Table 6**
**Purchased Allergy Products by Demographics (%)**

| Demographics | Yes, Resp Purchd | Yes, Someone Else Purchd | Yes, Both Purchd | No One Purchd | DK |
|---|---|---|---|---|---|
| **Total** | **24.6** | **6.1** | **7.1** | **62.0** | **0.2** |
| **Gender*** | | | | | |
| Men | 14.5 | 11.7 | 13.1 | 60.0 | 0.7 |
| Women | 30.2 | 3.0 | 3.8 | 63.0 | 0 |
| **Age Group*** | | | | | |
| 18-24 | 16.7 | 5.6 | 13.9 | 61.1 | 2.8 |
| 25-34 | 33.3 | 7.4 | 14.8 | 44.4 | 0 |
| 35-44 | 39.7 | 7.4 | 8.8 | 44.1 | 0 |
| 45-54 | 28.8 | 9.6 | 4.1 | 57.5 | 0 |
| 55-64 | 17.2 | 4.7 | 10.9 | 67.2 | 0 |
| 65-74 | 16.9 | 6.8 | 0 | 76.3 | 0 |
| 75+ | 15.7 | 0 | 0 | 84.3 | 0 |
| **Education Level** | | | | | |
| High school or less | 21.9 | 4.1 | 4.7 | 68.6 | 0.6 |
| 1-3 yrs of college | 26.5 | 8.5 | 7.7 | 57.3 | 0 |
| BA or MA degree | 27.0 | 6.6 | 9.8 | 56.6 | 0 |
| **County Type** | | | | | |
| Rural | 11.5 | 11.5 | 0 | 76.9 | 0 |
| Mostly rural | 20.5 | 7.2 | 7.2 | 65.1 | 0 |
| Mostly urban | 25.9 | 4.4 | 6.7 | 63.0 | 0 |
| Urban | 27.7 | 6.0 | 8.4 | 57.2 | 0.6 |

*Significant at $p < .05$.

**Q2d:** In the past year has anyone in your household purchased any other products like these?

Nearly all (95%) of the respondents reported no household purchase of any other products than those already mentioned. Four percent reported purchasing other products by the respondent, less than 1% reported such purchasing by someone else or purchasing by both the respondent and someone else, and less than 1% said they did not know.

No significant differences were found among the demographic subgroups

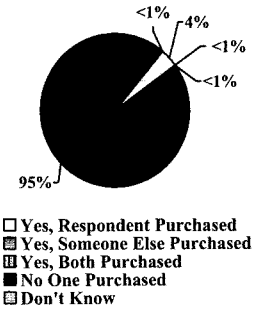



**Figure 10. Purchased Any Other Products**

**Table 7**
**Purchased Any Other Products by Demographics (%)**

| Demographics | Yes, Resp Purchd | Yes, Someone Else Purchd | Yes, Both Purchd | No One Purchd | DK |
|---|---|---|---|---|---|
| **Total** | 3.9 | 0.2 | 0.5 | 94.9 | 0.5 |
| **Gender** | | | | | |
| Men | 1.4 | 0.7 | 0 | 97.2 | 0.7 |
| Women | 5.3 | 0 | 0.8 | 93.6 | 0.4 |
| **Age Group** | | | | | |
| 18-24 | 0 | 0 | 2.8 | 97.2 | 0 |
| 25-34 | 1.9 | 0 | 1.9 | 96.3 | 0 |
| 35-44 | 0 | 0 | 0 | 100.0 | 0 |
| 45-54 | 9.6 | 1.4 | 0 | 87.7 | 1.4 |
| 55-64 | 6.3 | 0 | 0 | 92.2 | 1.6 |
| 65-74 | 5.1 | 0 | 0 | 94.9 | 0 |
| 75+ | 2.0 | 0 | 0 | 98.0 | 0 |
| **Education Level** | | | | | |
| High school or less | 4.1 | 0.6 | 0 | 95.3 | 0 |
| 1-3 yrs of college | 4.3 | 0 | 1.7 | 93.2 | 0.9 |
| BA or MA degree | 3.3 | 0 | 0 | 95.9 | 0.8 |
| **County Type** | | | | | |
| Rural | 0 | 0 | 0 | 100.0 | 0 |
| Mostly rural | 1.2 | 0 | 0 | 97.6 | 1.2 |
| Mostly urban | 5.2 | 0 | 0.7 | 94.1 | 0 |
| Urban | 4.8 | 0.6 | 0.6 | 93.4 | 0.6 |

**Summary of Q2a–Q2d**: Any household purchase of any nasal congestion, cold, flu, or allergy medications?

A summary variable was created to combine the responses to Q2a through Q2d. While only 54% of the sample had indicated any household purchase within the last year of a pseudoephedrine product in response to the general wording of Q1, the estimate increased to 84% in response to the more specific questions in Q2a-Q2d. The latter should be considered to be the more accurate estimate. Only 16% of respondent households had not purchased any of these medications.

Similar to Q1, with the exception of 18-24 year olds, as age increased, the percent of household purchases decreased. Also, respondents with higher education levels reported a higher rate of household purchases than did those with less education.

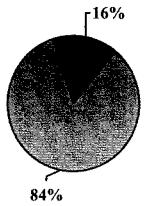



**Figure 11. Household Purchased at Least One of these Medications**

**Table 8**
**Household Purchased at Least One Medication by Demographics (%)**

| Demographics | Yes, HH Purchased Medication | No HH Purchases |
|---|---|---|
| **Total** | **83.9** | **16.1** |
| **Gender** | | |
| Men | 84.1 | 15.9 |
| Women | 83.8 | 16.2 |
| **Age Group*** | | |
| 18-24 | 83.3 | 16.7 |
| 25-34 | 92.6 | 7.4 |
| 35-44 | 91.2 | 8.8 |
| 45-54 | 89.0 | 11.0 |
| 55-64 | 78.1 | 21.9 |
| 65-74 | 79.7 | 20.3 |
| 75+ | 72.5 | 27.5 |
| **Education Level*** | | |
| High school or less | 78.1 | 21.9 |
| 1-3 yrs of college | 86.3 | 13.7 |
| BA or MA degree | 90.2 | 9.8 |
| **County Type** | | |
| Rural | 84.6 | 15.4 |
| Mostly rural | 80.7 | 19.3 |
| Mostly urban | 84.4 | 15.6 |
| Urban | 84.9 | 15.1 |

*Significant at $p < .05$.

## *Location, Quantity, and Frequency of Medication Purchases*

**Q3:** At which type of store does your household MOST OFTEN buy these types of medications?

Nearly one-half (48%) of respondents purchased the medications from a retail or department store. Less than one-third (31%) purchased them from a drug store, 13% from a grocery store, 6% from several different places, 1% from a hospital or clinic pharmacy or from another retail store, and less than 1% from a convenience store or from some other source. Less than 1% said they did not know.

More women (54%) than men (35%) purchased the medications from a retail or department store. However, more men than women purchased the medications from drug stores (39% vs 26%) or from grocery stores (16% vs 11%).

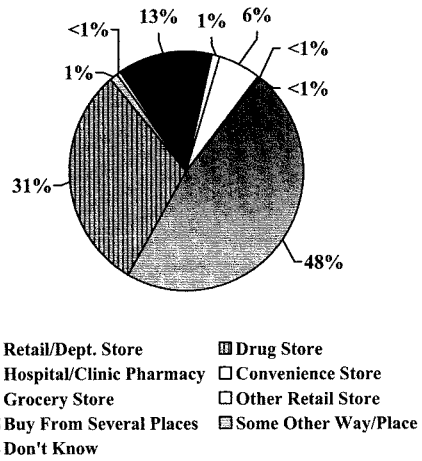



**Figure 12. Place Medications were Purchased**

**Table 9**
**Place Medications were Purchased by Demographics (%)**

| Demographics | Retail/ Dept Store | Drug Stores | Hospital/ Clinic Pharmacies | Convenience Stores | Grocery Stores | Other Retail Stores | Buy From Several Places | Some Other Way/Place | DK |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | **47.4** | **30.5** | **1.2** | **0.3** | **13.1** | **1.2** | **5.8** | **0.3** | **0.3** |
| **Gender*** | | | | | | | | | |
| Men | 35.2 | 39.3 | 2.5 | 0 | 16.4 | 1.6 | 4.9 | 0 | 0 |
| Women | 54.1 | 25.7 | 0.5 | 0.5 | 11.3 | 0.9 | 6.3 | 0.5 | 0.5 |
| **Age Group** | | | | | | | | | |
| 18-24 | 60.0 | 16.7 | 0 | 0 | 20.0 | 0 | 3.3 | 0 | 0 |
| 25-34 | 64.0 | 22.0 | 0 | 0 | 8.0 | 0 | 6.0 | 0 | 0 |
| 35-44 | 50.0 | 22.6 | 0 | 1.6 | 16.1 | 3.2 | 6.5 | 0 | 0 |
| 45-54 | 46.2 | 29.2 | 1.5 | 0 | 18.5 | 0 | 4.6 | 0 | 0 |
| 55-64 | 46.0 | 36.0 | 2.0 | 0 | 8.0 | 0 | 8.0 | 0 | 0 |
| 65-74 | 40.4 | 38.3 | 4.3 | 0 | 8.5 | 2.1 | 4.3 | 2.1 | 0 |
| 75+ | 27.0 | 51.4 | 0 | 0 | 8.1 | 2.7 | 8.1 | 0 | 2.7 |
| **Education Level** | | | | | | | | | |
| High school or less | 55.3 | 25.8 | 2.3 | 0 | 9.1 | 1.5 | 4.5 | 0.8 | 0.8 |
| 1-3 yrs of college | 46.5 | 28.7 | 1.0 | 0 | 16.8 | 2.0 | 5.0 | 0 | 0 |
| BA or MA degree | 39.1 | 37.3 | 0 | 0.9 | 14.5 | 0 | 8.2 | 0 | 0 |
| **County Type** | | | | | | | | | |
| Rural | 59.1 | 27.3 | 0 | 0 | 0 | 4.5 | 9.1 | 0 | 0 |
| Mostly rural | 55.2 | 25.4 | 1.5 | 0 | 7.5 | 1.5 | 7.5 | 1.5 | 0 |
| Mostly urban | 55.3 | 21.9 | 1.8 | 0 | 14.9 | 0 | 5.3 | 0 | 0.9 |
| Urban | 35.5 | 40.4 | 0.7 | 0.7 | 16.3 | 14 | 5.0 | 0 | 0 |

*Significant at $p < .05$.

**Q4:** When these types of medications are purchased by you or others in your household, how MANY packages or bottles are usually purchased at any one time?

An overwhelming majority of sample households (95%) reported purchasing only one package or bottle of medications containing pseudoephedrine at any one time.

The number of packages or bottles purchased did not differ significantly by gender, age group, education level, and county type.

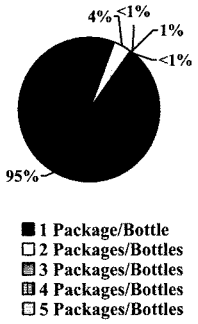



**Figure 13. Amount of Medications Purchased**

**Table 10**
**Amount of Medications Purchased by Demographics (%)**

| | Number of Packages or Bottles | | | | |
|---|---|---|---|---|---|
| **Demographics** | **1** | **2** | **3** | **4** | **5** |
| **Total** | **94.7** | **4.1** | **0.6** | **0.3** | **0.3** |
| **Gender** | | | | | |
| Men | 93.3 | 4.2 | 0.8 | 0.8 | 0.8 |
| Women | 95.4 | 4.1 | 0.5 | 0 | 0 |
| **Age Group** | | | | | |
| 18-24 | 93.3 | 3.3 | 0 | 3.3 | 0 |
| 25-34 | 96.0 | 4.0 | 0 | 0 | 0 |
| 35-44 | 95.2 | 1.6 | 1.6 | 0 | 1.6 |
| 45-54 | 93.8 | 6.3 | 0 | 0 | 0 |
| 55-64 | 100.0 | 0 | 0 | 0 | 0 |
| 65-74 | 91.1 | 8.9 | 0 | 0 | 0 |
| 75+ | 91.2 | 5.9 | 2.9 | 0 | 0 |
| **Education Level** | | | | | |
| High school or less | 93.8 | 3.1 | 1.6 | 0.8 | 0.8 |
| 1-3 yrs of college | 94.0 | 6.0 | 0 | 0 | 0 |
| BA or MA degree | 96.4 | 3.6 | 0 | 0 | 0 |
| **County Type** | | | | | |
| Rural | 90.5 | 9.5 | 0 | 0 | 0 |
| Mostly rural | 93.9 | 6.1 | 0 | 0 | 0 |
| Mostly urban | 93.8 | 4.5 | 0.9 | 0.9 | 0 |
| Urban | 96.4 | 2.2 | 0.7 | 0 | 0.7 |

**Q5:** How OFTEN would you say someone in your household usually buys these types of medications? Would you say…

Nearly three-fourths (73%) of respondent households purchased these types of medications *a few times per year* (i.e., less than six times a year). Eleven percent of respondent households purchased the medications *less than once per year*. About 8% purchased the medications most months of the year, 7% purchased them *monthly*, and 1% purchased them *weekly*.

The distribution of frequency of household purchases by gender, age group, education level, and county type revealed no significant differences.

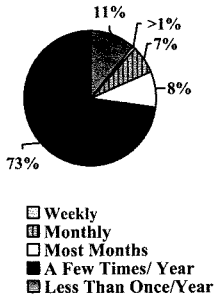



**Figure 14. Frequency of Medications Purchased**

**Table 11**
**Frequency of Medications Purchased by Demographics (%)**

| Demographics | Weekly | Monthly | Most Months | A Few Times/Year | Less Than Once/Year |
|---|---|---|---|---|---|
| **Total** | **0.9** | **6.7** | **8.5** | **73.0** | **10.9** |
| **Gender** | | | | | |
| Men | 0 | 7.5 | 6.7 | 74.2 | 11.7 |
| Women | 1.4 | 6.3 | 9.5 | 72.4 | 10.4 |
| **Age Group** | | | | | |
| 18-24 | 0 | 6.7 | 13.3 | 73.3 | 6.7 |
| 25-34 | 0 | 8.0 | 12.0 | 68.0 | 12.0 |
| 35-44 | 1.6 | 0 | 8.1 | 80.6 | 9.7 |
| 45-54 | 1.6 | 6.3 | 9.4 | 73.4 | 9.4 |
| 55-64 | 0 | 6.0 | 6.0 | 78.0 | 10.0 |
| 65-74 | 2.2 | 8.7 | 4.3 | 67.4 | 17.4 |
| 75+ | 0 | 16.7 | 8.3 | 66.7 | 8.3 |
| **Education Level** | | | | | |
| High school or less | 0.8 | 3.8 | 7.7 | 73.1 | 14.6 |
| 1-3 yrs of college | 1.0 | 9.9 | 7.9 | 71.3 | 9.9 |
| BA or MA degree | 0.9 | 6.4 | 10.1 | 75.2 | 7.3 |
| **County Type** | | | | | |
| Rural | 0 | 0 | 19.0 | 66.7 | 14.3 |
| Mostly rural | 0 | 6.0 | 4.5 | 74.6 | 14.9 |
| Mostly urban | 1.8 | 7.0 | 9.6 | 68.4 | 13.2 |
| Urban | 0.7 | 7.9 | 7.9 | 77.0 | 6.5 |

### *Heard of Using Pseudoephedrine to Manufacture Methamphetamine?*

**Q6:** In Iowa and elsewhere, some people are removing the pseudoephedrine from these medications to manufacture methamphetamine, commonly known as meth. Have you ever heard that this was happening?

Approximately one-half (52%) of the respondents have heard that some people remove the pseudoephedrine from these medications in order to manufacture methamphetamine. Forty-seven percent had not heard of this happening and 1% did not know.

The distribution of whether or not respondents had heard of this happening differed only by education level. Awareness was greater for those with more than a high school education.

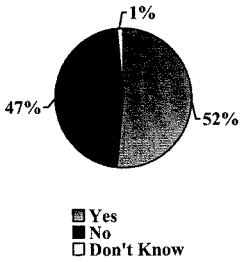



**Figure 15. Heard of Pseudoephedrine to Manufacture Methamphetamine**

**Table 12**
**Heard of Pseudoephedrine to Manufacture Meth by Demographics (%)**

| Demographics | Yes | No | DK |
|---|---|---|---|
| **Total** | **51.7** | **46.8** | **1.5** |
| **Gender** | | | |
| Men | 51.7 | 45.5 | 2.8 |
| Women | 51.7 | 47.5 | 0.8 |
| **Age Group** | | | |
| 18-24 | 38.9 | 61.1 | 0 |
| 25-34 | 59.3 | 38.9 | 1.9 |
| 35-44 | 55.9 | 44.1 | 0 |
| 45-54 | 58.9 | 41.1 | 0 |
| 55-64 | 51.6 | 46.9 | 1.6 |
| 65-74 | 47.5 | 49.2 | 3.4 |
| 75+ | 39.2 | 56.9 | 3.9 |
| **Education Level*** | | | |
| High school or less | 43.8 | 53.3 | 3.0 |
| 1-3 yrs of college | 59.8 | 40.2 | 0 |
| BA or MA degree | 55.7 | 43.4 | 0.8 |
| **County Type** | | | |
| Rural | 53.8 | 42.3 | 3.8 |
| Mostly rural | 51.8 | 45.8 | 2.4 |
| Mostly urban | 57.8 | 42.2 | 0 |
| Urban | 46.4 | 51.8 | 1.8 |

*Significant at $p < .05$.

### *Is the Manufacture of Meth Using Psuedoephedrine a Problem?*

**Q7:** Do you think the manufacture of meth using pseudoephedrine is a major problem, a minor problem, or not a problem at all?

One-half of respondents (50%) viewed the manufacture of meth using pseudoephedrine to be a *major* problem. Twelve percent thought it was a *minor* problem, 4% thought it was *not a problem at all*, and 34% said they did not know.

The demographic breakdown for this question showed that more of those in the middle age groups considered the manufacture of meth using pseudoephedrine to be a *major* problem; the youngest were especially less inclined to express this view.

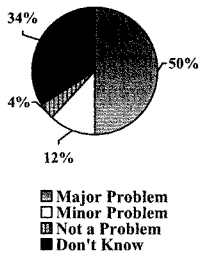



**Figure 16. Problem of Meth Using Pseudoephedrine**

**Table 13**
**Problem of Meth Using Pseudoephedrine by Demographics (%)**

| Demographics | Major Problem | Minor Problem | Not a Problem | DK |
|---|---|---|---|---|
| **Total** | **50.0** | **12.0** | **4.1** | **33.9** |
| **Gender** | | | | |
| Men | 45.5 | 13.8 | 6.2 | 34.5 |
| Women | 52.5 | 10.9 | 3.0 | 33.6 |
| **Age Group*** | | | | |
| 18-24 | 33.3 | 38.9 | 2.8 | 25.0 |
| 25-34 | 61.1 | 1.9 | 7.4 | 29.6 |
| 35-44 | 42.6 | 14.7 | 5.9 | 36.8 |
| 45-54 | 49.3 | 17.8 | 4.1 | 28.8 |
| 55-64 | 59.4 | 4.7 | 3.1 | 32.8 |
| 65-74 | 52.5 | 8.5 | 0 | 39.0 |
| 75+ | 43.1 | 5.9 | 5.9 | 45.1 |
| **Education Level** | | | | |
| High school or less | 47.9 | 10.1 | 3.0 | 39.1 |
| 1-3 yrs of college | 49.6 | 13.7 | 6.0 | 30.8 |
| BA or MA degree | 53.3 | 13.1 | 3.3 | 30.3 |
| **County Type** | | | | |
| Rural | 53.8 | 19.2 | 3.8 | 23.1 |
| Mostly rural | 48.2 | 9.6 | 2.4 | 39.8 |
| Mostly urban | 49.6 | 11.9 | 5.2 | 33.3 |
| Urban | 50.6 | 12.0 | 4.2 | 33.1 |

*Significant at $p < .05$.

## *Attitudes Toward Purchasing Restrictions*

**Q8a:** How much of an inconvenience to you would it be if people were limited in the quantity of these medications they could buy at one time?

Two-thirds (66%) of respondents reported that there would be *no inconvenience at all* to them if they were limited in the quantity of these medications they could buy at one time. Nineteen percent reported that it would be a *small inconvenience* to limit purchases, 8% thought it would be a *moderate inconvenience*, 5% thought it would be a *large inconvenience*, and 2% did not know.

The degree of inconvenience for limiting the quantity that could be purchased at one time differed by age. Nearly one-half (47%) of 18-24 year olds reported that there would be at least some inconvenience if the quantity of buying these medications were limited. Other age groups expressed less concern.

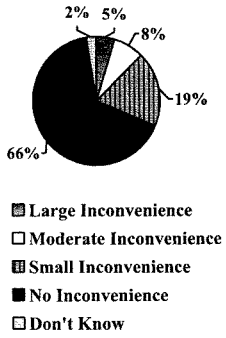



**Figure 17. Inconvenience of Limiting Quantity of Medications Purchased**

**Table 14**
**Inconvenience of Limiting Quantity of Medications Purchased by Demographics (%)**

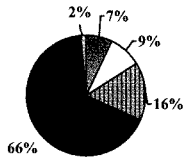
| Demographics | Large Inconv. | Moderate Inconv. | Small Inconv. | No Inconv. | DK |
|---|---|---|---|---|---|
| **Total** | **4.6** | **8.0** | **18.8** | **66.1** | **2.4** |
| **Gender** | | | | | |
| Men | 6.9 | 8.3 | 17.9 | 63.4 | 3.4 |
| Women | 3.4 | 7.9 | 19.2 | 67.5 | 1.9 |
| **Age Group*** | | | | | |
| 18-24 | 2.8 | 11.1 | 33.3 | 52.8 | 0 |
| 25-34 | 1.9 | 3.7 | 16.7 | 75.9 | 1.9 |
| 35-44 | 8.8 | 10.3 | 16.2 | 64.7 | 0 |
| 45-54 | 2.7 | 6.8 | 27.4 | 63.0 | 0 |
| 55-64 | 6.3 | 14.1 | 18.8 | 56.3 | 4.7 |
| 65-74 | 1.7 | 3.4 | 15.3 | 76.3 | 3.4 |
| 75+ | 7.8 | 7.8 | 7.8 | 68.6 | 7.8 |
| **Education Level** | | | | | |
| High school or less | 5.3 | 8.9 | 20.7 | 62.1 | 3.0 |
| 1-3 yrs of college | 3.4 | 6.8 | 21.4 | 65.0 | 3.4 |
| BA or MA degree | 4.9 | 8.2 | 13.1 | 73.0 | 0.8 |
| **County Type** | | | | | |
| Rural | 0 | 7.7 | 19.2 | 73.1 | 0 |
| Mostly rural | 6.0 | 3.6 | 20.5 | 69.9 | 0 |
| Mostly urban | 2.2 | 13.3 | 17.0 | 64.4 | 3.0 |
| Urban | 6.6 | 6.0 | 19.3 | 64.5 | 3.6 |

*Significant at $p < .05$.

**Q8b:** How much of an inconvenience to you would it be if people had to show a photo-ID to buy them?

Two-thirds (67%) of respondents reported that it would be *no inconvenience at all* if they were asked to show a photo-ID to purchase these medications. Sixteen percent reported that it would be a *small inconvenience* to show a photo-ID, 9% thought it would be a *moderate inconvenience*, 7% thought it would be a *large inconvenience*, and 2% did not know.

The degree of inconvenience for showing a photo-ID to make these purchases differed by gender. While both values are small, almost twice as many men as women (10% vs. 6%) reported that it would be a *large inconvenience* to show a photo-ID.




- Large Inconvenience
- Moderate Inconvenience
- Small Inconvenience
- No Inconvenience
- Don't Know

**Figure 18. Inconvenience of Showing Photo-ID to Purchase the Medications**

**Table 15**
**Inconvenience of Showing Photo-ID to Purchase the Medications by Demographics (%)**

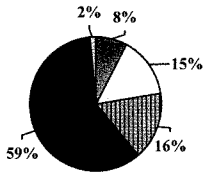
| Demographics | Large Inconv. | Moderate Inconv. | Small Inconv. | No Inconv. | DK |
|---|---|---|---|---|---|
| **Total** | **7.3** | **8.8** | **15.6** | **66.8** | **1.5** |
| **Gender*** | | | | | |
| Men | 10.3 | 11.0 | 11.0 | 64.8 | 2.8 |
| Women | 5.7 | 7.5 | 18.1 | 67.9 | 0.8 |
| **Age Group** | | | | | |
| 18-24 | 13.9 | 13.9 | 19.4 | 50.0 | 2.8 |
| 25-34 | 3.7 | 7.4 | 22.2 | 64.8 | 1.9 |
| 35-44 | 13.2 | 10.3 | 19.1 | 57.4 | 0 |
| 45-54 | 8.2 | 8.2 | 19.2 | 64.4 | 0 |
| 55-64 | 3.1 | 7.8 | 15.6 | 73.4 | 0 |
| 65-74 | 5.1 | 5.1 | 3.4 | 83.1 | 3.4 |
| 75+ | 5.9 | 9.8 | 11.8 | 68.6 | 3.9 |
| **Education Level** | | | | | |
| High school or less | 6.5 | 10.1 | 13.6 | 67.5 | 2.4 |
| 1-3 yrs of college | 7.7 | 8.5 | 17.1 | 65.0 | 1.7 |
| BA or MA degree | 8.2 | 7.4 | 17.2 | 67.2 | 0 |
| **County Type** | | | | | |
| Rural | 3.8 | 3.8 | 23.1 | 61.5 | 7.7 |
| Mostly rural | 7.2 | 4.8 | 13.3 | 74.7 | 0 |
| Mostly urban | 8.1 | 8.1 | 14.1 | 68.1 | 1.5 |
| Urban | 7.2 | 12.0 | 16.9 | 62.7 | 1.2 |

*Significant at $p < .05$.

**Q8c:** How much of an inconvenience to you would it be if people had to ask a pharmacist or clerk for them?

About six in ten (59%) respondents reported that there would be *no inconvenience at all* if they had to ask a pharmacist or clerk for the medications. Sixteen percent reported that it would be a *small inconvenience*, 15% thought it would be a *moderate inconvenience*, 8% thought it would be a *large inconvenience*, and 2% did not know.

The degree of inconvenience for asking a pharmacist or clerk for the medications differed by age group and education level. Two-thirds (67%) of 18-24 year olds reported that there would be at least some inconvenience if they had to ask a pharmacist or clerk for the medications. About 15% of 35-44 year olds thought it would be a *large inconvenience* if they had to ask for the medications. Slightly more of those with college degrees described the level of inconvenience to be large or moderate, compared to those with less education.




- Large Inconvenience
- Moderate Inconvenience
- Small Inconvenience
- No Inconvenience
- Don't Know

**Figure 19. Inconvenience of Asking Pharmacist/clerk for the Medications**

**Table 16**
**Inconvenience of Asking Pharmacist/clerk for the Medications by Demographics (%)**

| Demographics | Large Inconv. | Moderate Inconv. | Small Inconv. | No Inconv. | DK |
|---|---|---|---|---|---|
| **Total** | **7.8** | **14.6** | **16.6** | **59.5** | **1.5** |
| **Gender** | | | | | |
| Men | 8.3 | 12.4 | 16.6 | 61.4 | 1.4 |
| Women | 7.5 | 15.8 | 16.6 | 58.5 | 1.5 |
| **Age Group*** | | | | | |
| 18-24 | 5.6 | 27.8 | 33.3 | 33.3 | 0 |
| 25-34 | 5.6 | 24.1 | 13.0 | 57.4 | 0 |
| 35-44 | 14.7 | 13.2 | 22.1 | 50.0 | 0 |
| 45-54 | 9.6 | 13.7 | 15.1 | 61.6 | 0 |
| 55-64 | 4.7 | 17.2 | 14.1 | 60.9 | 3.1 |
| 65-74 | 6.8 | 6.8 | 11.9 | 72.9 | 1.7 |
| 75+ | 5.9 | 5.9 | 13.7 | 68.6 | 5.9 |
| **Education Level*** | | | | | |
| High school or less | 7.7 | 13.6 | 14.2 | 60.9 | 3.6 |
| 1-3 yrs of college | 5.1 | 11.1 | 23.9 | 59.8 | 0 |
| BA or MA degree | 10.7 | 19.7 | 13.1 | 56.6 | 0 |
| **County Type** | | | | | |
| Rural | 3.8 | 15.4 | 15.4 | 65.4 | 0 |
| Mostly rural | 7.2 | 10.8 | 14.5 | 65.1 | 2.4 |
| Mostly urban | 5.9 | 14.1 | 14.1 | 63.7 | 2.2 |
| Urban | 10.2 | 16.9 | 19.9 | 52.4 | 0.6 |

*Significant at $p < .05$.

**Q9a:** How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people were limited in the quantity of these medications they could buy at one time?

Overall, 69% thought limiting the quantity to be purchased at one time would be at least *somewhat effective*, with 40% saying it would be *moderately or very effective*. Specifically, less than one-third (29%) thought it would be *somewhat effective* if the quantity people could buy at one time were limited. Nearly one-fourth (23%) thought this would be *moderately effective*, 17% thought it would be *very effective*, 19% thought it would be *not effective at all*, and 12% did not know.

The level of effectiveness for limiting the quantity of medications that could be purchased at one time differed by age group and education level. There were modest patterns for greater effectiveness to be associated with increasing age, but with decreasing levels of education.

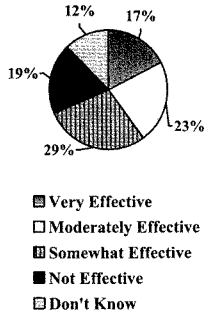



**Figure 20. Effectiveness of Limiting Quantity of Medications Purchased**

**Table 17**
**Effectiveness of Limiting Quantity of Medications Purchased by Demographics (%)**

| Demographics | Very Effective | Moderately Effective | Somewhat Effective | Not Effective | DK |
|---|---|---|---|---|---|
| **Total** | **17.4** | **22.7** | **28.4** | **19.3** | **12.2** |
| **Gender** | | | | | |
| Men | 11.0 | 23.4 | 29.0 | 24.1 | 12.4 |
| Women | 20.8 | 22.3 | 28.0 | 16.7 | 12.1 |
| **Age Group*** | | | | | |
| 18-24 | 8.6 | 22.9 | 31.4 | 31.4 | 5.7 |
| 25-34 | 9.3 | 27.8 | 25.9 | 29.6 | 7.4 |
| 35-44 | 16.2 | 30.9 | 32.4 | 13.2 | 7.4 |
| 45-54 | 19.2 | 23.3 | 24.7 | 21.9 | 11.0 |
| 55-64 | 23.4 | 18.8 | 28.1 | 15.6 | 14.1 |
| 65-74 | 20.3 | 20.3 | 39.0 | 8.5 | 11.9 |
| 75+ | 19.6 | 15.7 | 15.7 | 21.6 | 27.5 |
| **Education Level*** | | | | | |
| High school or less | 20.8 | 19.6 | 29.2 | 13.7 | 16.7 |
| 1-3 yrs of college | 14.5 | 29.1 | 26.5 | 23.9 | 6.0 |
| BA or MA degree | 15.6 | 20.5 | 29.5 | 22.1 | 12.3 |
| **County Type** | | | | | |
| Rural | 7.7 | 15.4 | 38.5 | 15.4 | 23.1 |
| Mostly rural | 20.7 | 22.0 | 22.0 | 23.2 | 12.2 |
| Mostly urban | 20.0 | 26.7 | 26.7 | 17.0 | 9.6 |
| Urban | 15.1 | 21.1 | 31.3 | 19.9 | 12.7 |

*Significant at $p < .05$.

**Q9b:** How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to show a photo-ID to buy them?

Overall, 73% thought showing a photo ID to purchase these products would be at least *somewhat effective*, with 49% saying it would be *moderately or very effective*. Specifically, nearly one-fourth (24%) thought it would be *somewhat effective* if people had to show a photo-ID, one-fourth (26%) thought this would be *moderately effective*, 23% thought it would be *very effective*, 19% thought it would be *not effective at all*, and 8% did not know.

The effectiveness of having people show a photo-ID to purchase the medications revealed no significant differences by demographic subgroups.

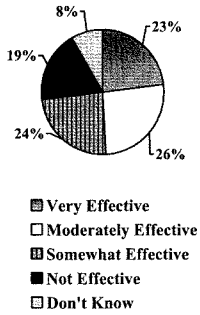



**Figure 21. Effectiveness of Showing Photo-ID to Purchase the Medications**

**Table 18**
**Effectiveness of Showing Photo-ID to Purchase the Medications by Demographics (%)**

| Demographics | Very Effective | Moderately Effective | Somewhat Effective | Not Effective | DK |
|---|---|---|---|---|---|
| **Total** | **23.2** | **26.1** | **23.7** | **18.8** | **8.3** |
| **Gender** | | | | | |
| Men | 16.6 | 29.7 | 23.4 | 20.7 | 9.7 |
| Women | 26.8 | 24.2 | 23.8 | 17.7 | 7.5 |
| **Age Group** | | | | | |
| 18-24 | 8.3 | 33.3 | 19.4 | 33.3 | 5.6 |
| 25-34 | 16.7 | 29.6 | 25.9 | 24.1 | 3.7 |
| 35-44 | 22.1 | 32.4 | 25.0 | 14.7 | 5.9 |
| 45-54 | 21.9 | 28.8 | 23.3 | 20.5 | 5.5 |
| 55-64 | 26.6 | 15.6 | 21.9 | 21.9 | 14.1 |
| 65-74 | 30.5 | 23.7 | 23.7 | 11.9 | 10.2 |
| 75+ | 31.4 | 23.5 | 23.5 | 9.8 | 11.8 |
| **Education Level** | | | | | |
| High school or less | 26.6 | 28.4 | 23.7 | 13.0 | 8.3 |
| 1-3 yrs of college | 22.2 | 27.4 | 22.2 | 22.2 | 6.0 |
| BA or MA degree | 18.9 | 22.1 | 24.6 | 23.8 | 10.7 |
| **County Type** | | | | | |
| Rural | 11.5 | 26.9 | 42.3 | 11.5 | 7.7 |
| Mostly rural | 25.3 | 30.1 | 19.3 | 16.9 | 8.4 |
| Mostly urban | 23.7 | 28.9 | 19.3 | 19.3 | 8.9 |
| Urban | 23.5 | 21.7 | 26.5 | 20.5 | 7.8 |

**Q9c:** How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to ask a pharmacist or clerk for them?

Overall, 77% thought asking a pharmacist or clerk to purchase these products would be at least *somewhat effective*, with 57% saying it would be *moderately or very effective*. Specifically, a little more than one-fourth (28%) thought it would be *very effective* if people had to ask a pharmacist or clerk for the medications. The same percentage (28%) thought this would be *moderately effective*, 20% thought it would be *somewhat effective*, 15% thought it would be *not effective at all*, and 9% did not know.

The effectiveness of having people ask for the medications differed by age group. As age increased, the level of effectiveness also increased.

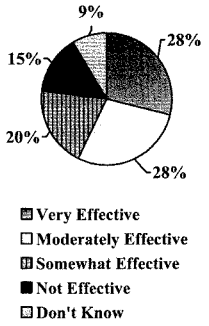



**Figure 22. Effectiveness of Asking Pharmacist/clerk for the Medications**

**Table 19**
**Effectiveness of Asking Pharmacist/clerk for the Medications by Demographics (%)**

| Demographics | Very Effective | Moderately Effective | Somewhat Effective | Not Effective | DK |
|---|---|---|---|---|---|
| **Total** | **28.8** | **28.5** | **19.5** | **14.6** | **8.5** |
| **Gender** | | | | | |
| Men | 22.1 | 28.3 | 22.1 | 18.6 | 9.0 |
| Women | 32.5 | 28.7 | 18.1 | 12.5 | 8.3 |
| **Age Group*** | | | | | |
| 18-24 | 11.1 | 36.1 | 27.8 | 19.4 | 5.6 |
| 25-34 | 20.4 | 31.5 | 24.1 | 22.2 | 1.9 |
| 35-44 | 25.0 | 38.2 | 16.2 | 14.7 | 5.9 |
| 45-54 | 30.1 | 28.8 | 24.7 | 13.7 | 2.7 |
| 55-64 | 31.3 | 23.4 | 18.8 | 14.1 | 12.5 |
| 65-74 | 37.3 | 23.7 | 18.6 | 8.5 | 11.9 |
| 75+ | 41.2 | 19.6 | 7.8 | 11.8 | 19.6 |
| **Education Level** | | | | | |
| High school or less | 33.7 | 26.6 | 18.3 | 10.1 | 11.2 |
| 1-3 yrs of college | 24.8 | 30.8 | 20.5 | 19.7 | 4.3 |
| BA or MA degree | 25.4 | 28.7 | 20.5 | 16.4 | 9.0 |
| **County Type** | | | | | |
| Rural | 26.9 | 26.9 | 19.2 | 19.2 | 7.7 |
| Mostly rural | 25.3 | 32.5 | 19.3 | 14.5 | 8.4 |
| Mostly urban | 30.4 | 31.1 | 19.3 | 11.9 | 7.4 |
| Urban | 29.5 | 24.7 | 19.9 | 16.3 | 9.6 |

*Significant at $p < .05$.

**Q10a:** Would you say you strongly support, moderately support, moderately oppose, or strongly oppose limiting the quantity of these mediations that can be bought at any one time?

Nearly one-half (49%) of respondents *strongly supported* limiting the quantity of medications that can be purchased at any one time. One-third (33%) *moderately supported* the limitation, 8% *moderately opposed* the limitation, 4% *strongly opposed* it, and 6% did not know or had no opinion.

More women than men (54% vs. 39%) *strongly supported* the limitation. More men than women *moderately* or *strongly opposed* this limitation. However, more than three-fourths of both women and men expressed support for the idea.

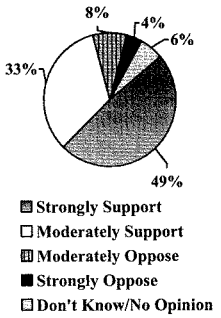



**Figure 23. Support for Limiting Quantity of Medications Purchased**

**Table 20**
**Support for Limiting Quantity of Medications Purchased by Demographics (%)**

| Demographics | Strongly Support | Moderately Support | Moderately Oppose | Strongly Oppose | DK/ No Opinion |
|---|---|---|---|---|---|
| **Total** | 48.5 | 33.4 | 8.3 | 3.9 | 5.9 |
| **Gender*** | | | | | |
| Men | 38.6 | 37.9 | 11.7 | 5.5 | 6.2 |
| Women | 54.0 | 30.9 | 6.4 | 3.0 | 5.7 |
| **Age Group** | | | | | |
| 18-24 | 33.3 | 41.7 | 13.9 | 5.6 | 5.6 |
| 25-34 | 57.4 | 27.8 | 11.1 | 0 | 3.7 |
| 35-44 | 47.1 | 39.7 | 4.4 | 2.9 | 5.9 |
| 45-54 | 53.4 | 32.9 | 4.1 | 6.8 | 2.7 |
| 55-64 | 48.4 | 31.3 | 12.5 | 1.6 | 6.3 |
| 65-74 | 52.5 | 32.2 | 6.8 | 5.1 | 3.4 |
| 75+ | 39.2 | 29.4 | 9.8 | 5.9 | 15.7 |
| **Education Level** | | | | | |
| High school or less | 47.3 | 30.2 | 11.2 | 3.6 | 7.7 |
| 1-3 yrs of college | 51.3 | 32.5 | 6.0 | 5.1 | 5.1 |
| BA or MA degree | 48.4 | 39.3 | 5.7 | 2.5 | 4.1 |
| **County Type** | | | | | |
| Rural | 50.0 | 30.8 | 15.4 | 0 | 3.8 |
| Mostly rural | 60.2 | 30.1 | 3.6 | 1.2 | 4.8 |
| Mostly urban | 47.4 | 34.1 | 9.6 | 3.0 | 5.9 |
| Urban | 43.4 | 34.9 | 8.4 | 6.6 | 6.6 |

*Significant at $p < .05$.

**Q10b:** Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring a photo-ID to be shown to buy them?

Nearly one-half (48%) of respondents *strongly supported* the requirement of showing a photo-ID to purchase the medications. About one-third (32%) *moderately supported* the requirement, 8% *moderately opposed* the requirement, 6% *strongly oppose* it, and 7% don't know or had no opinion.

More women (53%) than men (38%) *strongly supported* the requirement of showing a photo-ID to purchase the medications.

At least one-half of 25-34 and 45-74 year olds *strongly supported* this requirement; representing two to three times the same level of support within the youngest age group (18-24).

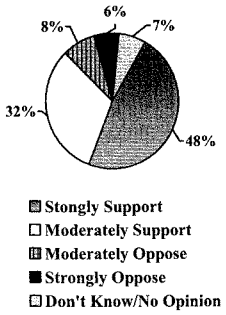



**Figure 24. Support for Showing Photo-ID to Purchase the Medications**

**Table 21**
**Support for Showing Photo-ID to Purchase the Medications by Demographics (%)**

| Demographics | Strongly Support | Moderately Support | Moderately Oppose | Strongly Oppose | DK/ No Opinion |
|---|---|---|---|---|---|
| **Total** | **47.6** | **31.7** | **8.0** | **6.1** | **6.6** |
| **Gender*** | | | | | |
| Men | 37.9 | 35.9 | 9.7 | 6.9 | 9.7 |
| Women | 52.8 | 29.4 | 7.2 | 5.7 | 4.9 |
| **Age Group*** | | | | | |
| 18-24 | 19.4 | 41.7 | 22.2 | 8.3 | 8.3 |
| 25-34 | 50.0 | 25.9 | 11.1 | 5.6 | 7.4 |
| 35-44 | 36.8 | 45.6 | 4.4 | 8.8 | 4.4 |
| 45-54 | 58.9 | 27.4 | 6.8 | 4.1 | 2.7 |
| 55-64 | 51.6 | 26.6 | 12.5 | 1.6 | 7.8 |
| 65-74 | 62.7 | 27.1 | 1.7 | 5.1 | 3.4 |
| 75+ | 41.2 | 29.4 | 3.9 | 9.8 | 15.7 |
| **Education Level** | | | | | |
| High school or less | 51.5 | 27.2 | 7.7 | 5.3 | 8.3 |
| 1-3 yrs of college | 43.6 | 37.6 | 5.1 | 8.5 | 5.1 |
| BA or MA degree | 46.7 | 31.1 | 11.5 | 4.9 | 5.7 |
| **County Type** | | | | | |
| Rural | 38.5 | 34.6 | 19.2 | 0 | 7.7 |
| Mostly rural | 56.6 | 30.1 | 6.0 | 2.4 | 4.8 |
| Mostly urban | 47.4 | 29.6 | 8.1 | 7.4 | 7.4 |
| Urban | 44.6 | 33.7 | 7.2 | 7.8 | 6.6 |

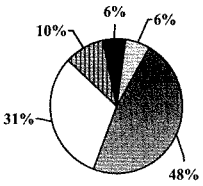
*Significant at $p < .05$.

**Q10c:** Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring one to ask a pharmacist or clerk for them?

Nearly one-half (48%) of respondents *strongly supported* the requirement of asking a pharmacist or clerk for the medications. About one-third (31%) *moderately supported* the requirement, 10% *moderately opposed* it, 6% *strongly opposed* it, and 6% didn't know or had no opinion.

More women (54%) than men (37%) *strongly supported* this requirement.

Over one-half of 45-54 year olds and respondents 65 and older *strongly supported* the requirement; which is more than two times that of the youngest age group (18-24).




- Stongly Support
- Moderately Support
- Moderately Oppose
- Strongly Oppose
- Don't Know/No Opinion

**Figure 25. Support for Asking Pharmacist/clerk for the Medications**

**Table 22**
**Support for Asking Pharmacist/clerk for the Medications by Demographics (%)**

| Demographics | Strongly Support | Moderately Support | Moderately Oppose | Strongly Oppose | DK/ No Opinion |
|---|---|---|---|---|---|
| **Total** | **47.6** | **31.0** | **9.8** | **5.6** | **6.1** |
| **Gender*** | | | | | |
| Men | 36.6 | 37.2 | 13.1 | 6.9 | 6.2 |
| Women | 53.6 | 27.5 | 7.9 | 4.9 | 6.0 |
| **Age Group*** | | | | | |
| 18-24 | 22.2 | 44.4 | 19.4 | 11.1 | 2.8 |
| 25-34 | 44.4 | 35.2 | 11.1 | 9.3 | 0 |
| 35-44 | 38.2 | 41.2 | 10.3 | 5.9 | 4.4 |
| 45-54 | 57.5 | 27.4 | 6.8 | 5.5 | 2.7 |
| 55-64 | 46.9 | 25.0 | 17.2 | 3.1 | 7.8 |
| 65-74 | 57.6 | 27.1 | 3.4 | 3.4 | 8.5 |
| 75+ | 54.9 | 19.6 | 3.9 | 3.9 | 17.6 |
| **Education Level** | | | | | |
| High school or less | 48.5 | 26.0 | 11.2 | 5.9 | 8.3 |
| 1-3 yrs of college | 47.0 | 34.2 | 6.8 | 6.0 | 6.0 |
| BA or MA degree | 47.5 | 33.6 | 10.7 | 4.9 | 3.3 |
| **County Type** | | | | | |
| Rural | 42.3 | 38.5 | 7.7 | 7.7 | 3.8 |
| Mostly rural | 56.6 | 27.7 | 9.6 | 1.2 | 4.8 |
| Mostly urban | 48.1 | 29.6 | 8.9 | 5.2 | 8.1 |
| Urban | 43.4 | 32.5 | 10.8 | 7.8 | 5.4 |

*Significant at $p < .05$.

# Summary

A random sample of 410 Iowa adults were interviewed by telephone in August, 2003. The interview asked respondents about their household purchasing habits for over-the-counter medications containing the ingredient pseudoephedrine, and for their views about possible changes in the ways these products could be purchased. The main findings were as follows:

A great majority of households (84%) had purchased these products at least once in the past year. More women than men reported such purchases.

Most often respondents bought the products at retail/department stores (48%) or from drug stores (31%).

By far (95%), only one bottle or package was reported to be bought at a time.

The usual frequency of such purchases (73%) was less than six times per year.

About one-half of the respondents (52%) said they had heard that medications containing pseudoephedrine were being used in the manufacture of methamphetamine, while 48% have not heard this.

Half of the respondents (50%) considered the manufacture of methamphetamine using pseudoephedrine to be a major problem. However, one-third (34%) said they did not know how to characterize it.

Three possible restrictions on the purchase of pseudoephedrine products were presented to the sample. For all three possible restrictions a greater percentage of respondents tended to respond positively rather than negatively.

For limiting the quantity that could be purchased at one time, over eight in ten (85%) said this would be of little or no inconvenience to them, four in ten (40%) thought this would be very or moderately effective, and about eight in ten (82%) strongly or moderately supported the idea. In contrast, one in eight (13%) said this would be a moderate or large inconvenience, five in ten (48%) thought this would be somewhat or not effective, and one in eight (12%) strongly or moderately opposed it.

For showing a photo ID to make a purchase, eight in ten (82%) said this would be of little or no inconvenience to them, one-half (49%) thought it would be very or moderately effective, and eight in ten (79%) strongly or moderately supported the idea. In contrast, one in six (17%) said this would be a moderate or large inconvenience, about four in ten (43%) thought this would be somewhat or not effective, and one in seven (14%) strongly or moderately opposed it.

For having to ask a pharmacist or clerk to make a purchase, three-fourths (76%) said this would be of little or no inconvenience to them, about six in ten (57%) thought it would be strongly or moderately effective, and eight in ten (79%) strongly or moderately supported the idea. In contrast, about one-fifth (22%) said this would be a moderate or large inconvenience, one-third (34%) thought it would be somewhat or not effective, and one in seven (15%) strongly or moderately opposed it.

Overall, roughly 80% of respondents tended to consider the possible restrictions not to be major inconveniences and to support the ideas. The respondents were more divided with respect to their predictions about whether the possible restrictions would be effective, with about 10% being uncertain.

Support for each of the three possible restrictions tended to be stronger for women than for men, and weaker for those in the youngest adult age group than for older adults. However, a majority of both genders and all age groups tended to support the ideas.

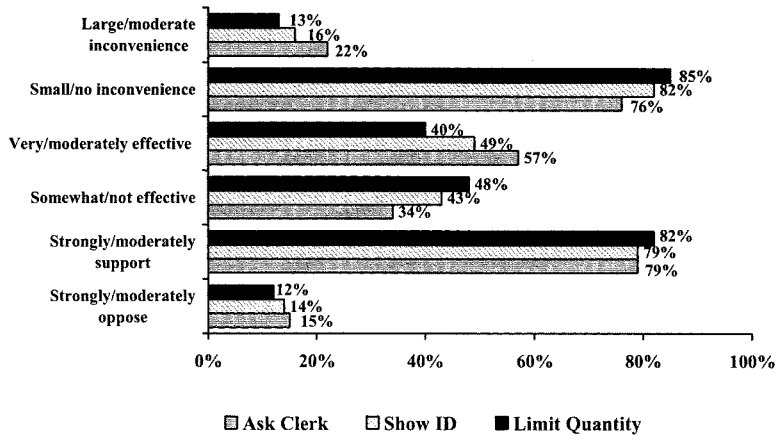



Figure 26. Summary of Public Views

# Appendices

**Table A-1**
**Frequencies of Categorical Variables by Gender and Age Group (%)**

| | | Gender | | Age Group | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Question** | **Total** | **Men** | **Women** | **18-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **Don't know** | **Refused** |
| **Q1. In the past year, has anyone in your household purchased any non-prescription medications for nasal decongestion, colds, flu or allergies?** | | | | | | | | | | | | |
| Yes | 53.9 | 51.0 | 55.5 | 50.0 | 74.1 | 73.5 | 60.3 | 46.9 | 35.6 | 33.3 | 0 | 25.0 |
| No | 44.6 | 46.2 | 43.8 | 41.7 | 24.1 | 26.5 | 39.7 | 51.6 | 64.4 | 64.7 | 100.0 | 75.0 |
| Don't know | 1.5 | 2.8 | .8 | 8.3 | 1.9 | 0 | 0 | 1.6 | 0 | 2.0 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q2a. In the past year, have you or anyone in your household purchased any cold and sinus products such as Actifed, Advil, Alka-Seltzer, Aleve, Cepacol, Comtrex, Contac, Dristan, Sine-Off, Sudafed, or Tylenol?** | | | | | | | | | | | | |
| Yes, respondent purchased | 48.8 | 34.5 | 56.6 | 19.4 | 55.6 | 60.3 | 56.2 | 39.1 | 47.5 | 49.0 | 0 | 75.0 |
| Yes, someone else in hh purchased | 11.7 | 21.4 | 6.4 | 27.8 | 5.6 | 10.3 | 16.4 | 9.4 | 13.6 | 3.9 | 0 | 0 |
| Yes, both respondent and someone else in hh purchased | 17.6 | 24.1 | 14.0 | 33.3 | 27.8 | 14.7 | 12.3 | 25.0 | 11.9 | 5.9 | 0 | 0 |
| No one in hh purchased | 21.7 | 20.0 | 22.6 | 19.4 | 11.1 | 14.7 | 15.1 | 25.0 | 27.1 | 41.2 | 100.0 | 25.0 |
| Don't know | .2 | 0 | .4 | 0 | 0 | 0 | 0 | 1.6 | 0 | 0 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q2b. In the past year, have you or anyone in your household purchased any cold and flu products such as Comtrex, TheraFlu, Robitussin, or Vicks?** | | | | | | | | | | | | |
| Yes, respondent purchased | 24.1 | 17.9 | 27.5 | 8.3 | 25.9 | 41.2 | 19.2 | 14.1 | 25.4 | 27.5 | 0 | 50.0 |
| Yes, someone else in hh purchased | 4.6 | 6.9 | 3.4 | 13.9 | 1.9 | 7.4 | 6.8 | 0 | 3.4 | 2.0 | 0 | 0 |
| Yes, both respondent and someone else in hh purchased | 7.6 | 12.4 | 4.9 | 19.4 | 16.7 | 5.9 | 4.1 | 9.4 | 3.4 | 0 | 0 | 0 |
| No one in hh purchased | 62.7 | 62.1 | 63.0 | 55.6 | 55.6 | 45.6 | 68.5 | 73.4 | 67.8 | 70.6 | 100.0 | 50.0 |
| Don't know | 1.0 | .7 | 1.1 | 2.8 | 0 | 0 | 1.4 | 3.1 | 0 | 0 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Total | Gender: Men | Gender: Women | Age Group: 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q2c. In the past year, have you or anyone in your household purchased any allergy products such as Benadryl, Chlor-Trimeton, Dristat, Sine-Off, Sinutab, or Triaminic?** | | | | | | | | | | | | |
| Yes, respondent purchased | 24.6 | 14.5 | 30.2 | 16.7 | 33.3 | 39.7 | 28.8 | 17.2 | 16.9 | 15.7 | 0 | 0 |
| Yes someone else in hh purchased | 6.1 | 11.7 | 3.0 | 5.6 | 7.4 | 7.4 | 9.6 | 4.7 | 6.8 | 0 | 0 | 0 |
| Yes, both respondent and someone else in hh purchased | 7.1 | 13.1 | 3.8 | 13.9 | 14.8 | 8.8 | 4.1 | 10.9 | 0 | 0 | 0 | 0 |
| No one in hh purchased | 62.0 | 60.0 | 63.0 | 61.1 | 44.4 | 44.1 | 57.5 | 67.2 | 76.3 | 84.3 | 100.0 | 100.0 |
| Don't know | .2 | .7 | 0 | 2.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q2d. In the past year, has anyone in your household purchased any other products like these?** | | | | | | | | | | | | |
| Yes, respondent purchased | 3.9 | 1.4 | 5.3 | 0 | 1.9 | 0 | 9.6 | 6.3 | 5.1 | 2.0 | 0 | 0 |
| Yes, someone else in hh purchased | .2 | .7 | 0 | 0 | 0 | 0 | 1.4 | 0 | 0 | 0 | 0 | 0 |
| Yes, both respondent and someone else in hh purchased | .5 | 0 | .8 | 2.8 | 1.9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No one in hh purchased | 94.9 | 97.2 | 93.6 | 97.2 | 96.3 | 100.0 | 87.7 | 92.2 | 94.9 | 98.0 | 100.0 | 100.0 |
| Don't know | .5 | .7 | .4 | 0 | 0 | 0 | 1.4 | 1.6 | 0 | 0 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Summary of Q2a-Q2d. Any household purchase of any nasal congestion, cold, flu, or allergy medications?** | | | | | | | | | | | | |
| Yes, household purchased at least one of these medications | 83.9 | 84.1 | 83.9 | 83.3 | 92.6 | 91.2 | 89.0 | 78.1 | 79.7 | 72.5 | 0 | 75.0 |
| No household purchase of any of these medications | 16.1 | 15.9 | 16.2 | 16.7 | 7.4 | 8.8 | 11.0 | 21.9 | 20.3 | 27.5 | 100.0 | 25.0 |

| Question | Total | Gender: Men | Gender: Women | Age Group: 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q3. At which type of store does your household MOST OFTEN buy these types of medications?** | | | | | | | | | | | | |
| Retail or dept. stores | 47.4 | 35.2 | 54.1 | 60.0 | 64.0 | 50.0 | 46.2 | 46.0 | 40.4 | 27.0 | -- | 0 |
| Drug stores | 30.5 | 39.3 | 25.7 | 16.7 | 22.0 | 22.6 | 29.2 | 36.0 | 38.3 | 51.4 | -- | 33.3 |
| Hospital or clinic pharmacies | 1.2 | 2.5 | .5 | 0 | 0 | 0 | 1.5 | 2.0 | 4.3 | 0 | -- | 0 |
| Convenience stores | .3 | 0 | .5 | 0 | 0 | 1.6 | 0 | 0 | 0 | 0 | -- | 0 |
| Grocery stores | 13.1 | 16.4 | 11.3 | 20.0 | 8.0 | 16.1 | 18.5 | 8.0 | 8.5 | 8.1 | -- | 66.7 |
| Some other retail store | 1.2 | 1.6 | .9 | 0 | 0 | 3.2 | 0 | 0 | 2.1 | 2.7 | -- | 0 |
| Buy from several places | 5.8 | 4.9 | 6.3 | 3.3 | 6.0 | 6.5 | 4.6 | 8.0 | 4.3 | 8.1 | -- | 0 |
| Some other place | .3 | 0 | .5 | 0 | 0 | 0 | 0 | 0 | 2.1 | 0 | -- | 0 |
| Don't know | .3 | 0 | .5 | 0 | 0 | 0 | 0 | 0 | 0 | 2.7 | -- | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q4. When these types of medications are purchased by you or others in your household, how MANY packages or bottles are usually purchased at any one time?** | | | | | | | | | | | | |
| 1 | 93.0 | 91.8 | 93.7 | 93.3 | 96.0 | 95.2 | 92.3 | 100.0 | 87.2 | 83.8 | -- | 100.0 |
| 2 | 4.1 | 4.1 | 4.1 | 3.3 | 4.0 | 1.6 | 6.2 | 0 | 8.5 | 5.4 | -- | 0 |
| 3 | .6 | .8 | .5 | 0 | 0 | 1.6 | 0 | 0 | 0 | 2.7 | -- | 0 |
| 4 | .3 | .8 | 0 | 3.3 | 0 | 0 | 0 | 0 | 0 | 0 | -- | 0 |
| 5 | .3 | .8 | 0 | 0 | 0 | 1.6 | 0 | 0 | 0 | 0 | -- | 0 |
| Don't know | 1.7 | 1.6 | 1.8 | 0 | 0 | 0 | 1.5 | 0 | 4.3 | 8.1 | -- | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q5. How OFTEN would you say someone in your household usually buys these types of medications? Would you say...** | | | | | | | | | | | | |
| Weekly | .9 | 0 | 1.4 | 0 | 0 | 1.6 | 1.5 | 0 | 2.1 | 0 | -- | 0 |
| Monthly | 6.7 | 7.4 | 6.3 | 6.7 | 8.0 | 0 | 6.2 | 6.0 | 8.5 | 16.2 | -- | 0 |
| Most months/year [6 or more months] | 8.4 | 6.6 | 9.5 | 13.3 | 12.0 | 8.1 | 9.2 | 6.0 | 4.3 | 8.1 | -- | 0 |
| Few times/year [1-5 months] | 72.4 | 73.0 | 72.1 | 73.3 | 68.0 | 80.6 | 72.3 | 78.0 | 66.0 | 64.9 | -- | 66.7 |
| Less than once a year | 10.8 | 11.5 | 10.4 | 6.7 | 12.0 | 9.7 | 9.2 | 10.0 | 17.0 | 8.1 | -- | 33.3 |
| Don't know | .9 | 1.6 | .5 | 0 | 0 | 0 | 1.5 | 0 | 2.1 | 2.7 | -- | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Total | Gender: Men | Gender: Women | Age Group: 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q6. In Iowa and elsewhere, some people are removing the pseudoephedrine from these medications to manufacture methamphetamine, commonly known as meth. Have you ever heard that this was happening?** | | | | | | | | | | | | |
| Yes | 51.7 | 51.7 | 51.7 | 38.9 | 59.3 | 55.9 | 58.9 | 51.6 | 47.5 | 39.2 | 100.0 | 75.0 |
| No | 46.8 | 45.5 | 47.5 | 61.1 | 38.9 | 44.1 | 41.1 | 46.9 | 49.2 | 56.9 | 0 | 25.0 |
| Don't know | 1.5 | 2.8 | .8 | 0 | 1.9 | 0 | 0 | 1.6 | 3.4 | 3.9 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q7. Do you think the manufacture of meth using pseudoephedrine is a major problem, a minor problem, or not a problem at all?** | | | | | | | | | | | | |
| Major problem | 50.0 | 45.5 | 52.5 | 33.3 | 61.1 | 42.6 | 49.3 | 59.4 | 52.5 | 43.1 | 100.0 | 75.0 |
| Minor problem | 12.0 | 13.8 | 10.9 | 38.9 | 1.9 | 14.7 | 17.8 | 4.7 | 8.5 | 5.9 | 0 | 0 |
| Not a problem | 4.1 | 6.2 | 3.0 | 2.8 | 7.4 | 5.9 | 4.1 | 3.1 | 0 | 5.9 | 0 | 0 |
| Don't know | 33.9 | 34.5 | 33.6 | 25.0 | 29.6 | 36.8 | 28.8 | 32.8 | 39.0 | 45.1 | 0 | 25.0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q8a. How much of an inconvenience to you would it be if people were limited in the quantity of these medications they could buy at one time?** | | | | | | | | | | | | |
| Large inconvenience | 4.6 | 6.9 | 3.4 | 2.8 | 1.9 | 8.8 | 2.7 | 6.3 | 1.7 | 7.8 | 0 | 0 |
| Moderate inconvenience | 8.0 | 8.3 | 7.9 | 11.1 | 3.7 | 10.3 | 6.8 | 14.1 | 3.4 | 7.8 | 0 | 0 |
| Small inconvenience | 18.8 | 17.9 | 19.2 | 33.3 | 16.7 | 16.2 | 27.4 | 18.8 | 15.3 | 7.8 | 0 | 0 |
| Not an inconvenience at all | 66.1 | 63.4 | 67.5 | 52.8 | 75.9 | 64.7 | 63.0 | 56.3 | 76.3 | 68.6 | 100.0 | 100.0 |
| Don't know | 2.4 | 3.4 | 1.9 | 0 | 1.9 | 0 | 0 | 4.7 | 3.4 | 7.8 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q8b. How much of an inconvenience to you would it be if people had to show a photo-ID to buy them?** | | | | | | | | | | | | |
| Large inconvenience | 7.3 | 10.3 | 5.7 | 13.9 | 3.7 | 13.2 | 8.2 | 3.1 | 5.1 | 5.9 | 0 | 0 |
| Moderate inconvenience | 8.8 | 11.0 | 7.5 | 13.9 | 7.4 | 10.3 | 8.2 | 7.8 | 5.1 | 9.8 | 0 | 25.0 |
| Small inconvenience | 15.6 | 11.0 | 18.1 | 19.4 | 22.2 | 19.1 | 19.2 | 15.6 | 3.4 | 11.8 | 0 | 0 |
| Not an inconvenience at all | 66.8 | 64.8 | 67.9 | 50.0 | 64.8 | 57.4 | 64.4 | 73.4 | 83.1 | 68.6 | 100.0 | 75.0 |
| Don't know | 1.5 | 2.8 | .8 | 2.8 | 1.9 | 0 | 0 | 0 | 3.4 | 3.9 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Total | Gender: Men | Gender: Women | Age Group: 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q8c. How much of an inconvenience to you would it be if people had to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Large inconvenience | 7.8 | 8.3 | 7.5 | 5.6 | 5.6 | 14.7 | 9.6 | 4.7 | 6.8 | 5.9 | 0 | 0 |
| Moderate inconvenience | 14.6 | 12.4 | 15.8 | 27.8 | 24.1 | 13.2 | 13.7 | 17.2 | 6.8 | 5.9 | 0 | 0 |
| Small inconvenience | 16.6 | 16.6 | 16.6 | 33.3 | 13.0 | 22.1 | 15.1 | 14.1 | 11.9 | 13.7 | 0 | 0 |
| Not an inconvenience at all | 59.5 | 61.4 | 58.5 | 33.3 | 57.4 | 50.0 | 61.6 | 60.9 | 72.9 | 68.6 | 100.0 | 100.0 |
| Don't know | 1.5 | 1.4 | 1.5 | 0 | 0 | 0 | 0 | 3.1 | 1.7 | 5.9 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q9a. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people were limited in the quantity of these medications they could buy at one time?** | | | | | | | | | | | | |
| Very effective | 17.3 | 11.0 | 20.8 | 8.3 | 9.3 | 16.2 | 19.2 | 23.4 | 20.3 | 19.6 | 100.0 | 0 |
| Moderately effective | 22.7 | 23.4 | 22.3 | 22.2 | 27.8 | 30.9 | 23.3 | 18.8 | 20.3 | 15.7 | 0 | 0 |
| Somewhat effective | 28.3 | 29.0 | 27.9 | 30.6 | 25.9 | 32.4 | 24.7 | 28.1 | 39.0 | 15.7 | 0 | 50.0 |
| Not at all effective | 19.3 | 24.1 | 16.6 | 30.6 | 29.6 | 13.2 | 21.9 | 15.6 | 8.5 | 21.6 | 0 | 25.0 |
| Don't know | 12.2 | 12.4 | 12.1 | 5.6 | 7.4 | 7.4 | 11.0 | 14.1 | 11.9 | 27.5 | 0 | 25.0 |
| Refused | .2 | 0 | .4 | 2.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Q9b. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to show a photo-ID to buy them?** | | | | | | | | | | | | |
| Very effective | 23.2 | 16.6 | 26.8 | 8.3 | 16.7 | 22.1 | 21.9 | 26.6 | 30.5 | 31.4 | 100.0 | 0 |
| Moderately effective | 26.1 | 29.7 | 24.2 | 33.3 | 29.6 | 32.4 | 28.8 | 15.6 | 23.7 | 23.5 | 0 | 0 |
| Somewhat effective | 23.7 | 23.4 | 23.8 | 19.4 | 25.9 | 25.0 | 23.3 | 21.9 | 23.7 | 23.5 | 0 | 50.0 |
| Not at all effective | 18.8 | 20.7 | 17.7 | 33.3 | 24.1 | 14.7 | 20.5 | 21.9 | 11.9 | 9.8 | 0 | 25.0 |
| Don't know | 8.3 | 9.7 | 7.5 | 5.6 | 3.7 | 5.9 | 5.5 | 14.1 | 10.2 | 11.8 | 0 | 25.0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Total | Gender: Men | Gender: Women | Age Group: 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q9c. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Very effective | 28.8 | 22.1 | 32.5 | 11.1 | 20.4 | 25.0 | 30.1 | 31.3 | 37.3 | 41.2 | 100.0 | 0 |
| Moderately effective | 28.5 | 28.3 | 28.7 | 36.1 | 31.5 | 38.2 | 28.8 | 23.4 | 23.7 | 19.6 | 0 | 25.0 |
| Somewhat effective | 19.5 | 22.1 | 18.1 | 27.8 | 24.1 | 16.2 | 24.7 | 18.8 | 18.6 | 7.8 | 0 | 25.0 |
| Not at all effective | 14.6 | 18.6 | 12.5 | 19.4 | 22.2 | 14.7 | 13.7 | 14.1 | 8.5 | 11.8 | 0 | 25.0 |
| Don't know | 8.5 | 9.0 | 8.3 | 5.6 | 1.9 | 5.9 | 2.7 | 12.5 | 11.9 | 19.6 | 0 | 25.0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q10a. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose limiting the quantity of these medication that can be bought at any one time?** | | | | | | | | | | | | |
| Strongly support | 48.5 | 38.6 | 54.0 | 33.3 | 57.4 | 47.1 | 53.4 | 48.4 | 52.5 | 39.2 | 100.0 | 50.0 |
| Moderately support | 33.4 | 37.9 | 30.9 | 41.7 | 27.8 | 39.7 | 32.9 | 31.3 | 32.2 | 29.4 | 0 | 50.0 |
| Moderately oppose | 8.3 | 11.7 | 6.4 | 13.9 | 11.1 | 4.4 | 4.1 | 12.5 | 6.8 | 9.8 | 0 | 0 |
| Strongly oppose | 3.9 | 5.5 | 3.0 | 5.6 | 0 | 2.9 | 6.8 | 1.6 | 5.1 | 5.9 | 0 | 0 |
| Don't know/No opinion | 5.9 | 6.2 | 5.7 | 5.6 | 3.7 | 5.9 | 2.7 | 6.3 | 3.4 | 15.7 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q10b. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring a photo-ID to be shown to buy them?** | | | | | | | | | | | | |
| Strongly support | 47.6 | 37.9 | 52.8 | 19.4 | 50.0 | 36.8 | 58.9 | 51.6 | 62.7 | 41.2 | 100.0 | 25.0 |
| Moderately support | 31.7 | 35.9 | 29.4 | 41.7 | 25.9 | 45.6 | 27.4 | 26.6 | 27.1 | 29.4 | 0 | 50.0 |
| Moderately oppose | 8.0 | 9.7 | 7.2 | 22.2 | 11.1 | 4.4 | 6.8 | 12.5 | 1.7 | 3.9 | 0 | 0 |
| Strongly oppose | 6.1 | 6.9 | 5.7 | 8.3 | 5.6 | 8.8 | 4.1 | 1.6 | 5.1 | 9.8 | 0 | 25.0 |
| Don't know/No opinion | 6.6 | 9.7 | 4.9 | 8.3 | 7.4 | 4.4 | 2.7 | 7.8 | 3.4 | 15.7 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Total | Gender | | Age Group | | | | | | | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Men | Women | 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | | |
| **Q10c. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring one to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Strongly support | 47.6 | 36.6 | 53.6 | 22.2 | 44.4 | 38.2 | 57.5 | 46.9 | 57.6 | 54.9 | 100.0 | 50.0 |
| Moderately support | 31.0 | 37.2 | 27.5 | 44.4 | 35.2 | 41.2 | 27.4 | 25.0 | 27.1 | 19.6 | 0 | 50.0 |
| Moderately oppose | 9.8 | 13.1 | 7.9 | 19.4 | 11.1 | 10.3 | 6.8 | 17.2 | 3.4 | 3.9 | 0 | 0 |
| Strongly oppose | 5.6 | 6.9 | 4.9 | 11.1 | 9.3 | 5.9 | 5.5 | 3.1 | 3.4 | 3.9 | 0 | 0 |
| Don't know/No opinion | 6.1 | 6.2 | 6.0 | 2.8 | 0 | 4.4 | 2.7 | 7.8 | 8.5 | 17.6 | 0 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

**Table A-2**
**Frequencies of Categorical Variables by Education Level and County Type (%)**

| | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Question | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q1. In the past year, has anyone in your household purchased any non-prescription medications for nasal decongestion, colds, flu or allergies?** | | | | | | | | | | | | |
| Yes | 20.0 | 42.9 | 45.1 | 60.7 | 59.1 | 76.5 | 0 | 0 | 34.6 | 53.0 | 53.3 | 57.8 |
| No | 80.0 | 52.4 | 54.9 | 36.8 | 39.8 | 23.5 | 0 | 100.0 | 61.5 | 45.8 | 45.9 | 40.4 |
| Don't know | 0 | 4.8 | 0 | 2.6 | 1.1 | 0 | 100.00 | 0 | 3.8 | 1.2 | .7 | 1.8 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q2a. In the past year, have you or anyone in your household purchased any cold and sinus products such as Actifed, Advil, Alka-Seltzer, Aleve, Caprasol, Contrex, Contac, Dristan, Sine-Off, Sudafed, or Tylenol?** | | | | | | | | | | | | |
| Yes, respondent purchased | 20.0 | 33.3 | 50.4 | 52.1 | 51.1 | 47.1 | 100.0 | -- | 46.2 | 44.6 | 55.6 | 45.8 |
| Yes, someone else in hh purchased | 13.3 | 9.5 | 12.0 | 12.8 | 11.4 | 8.8 | 0 | -- | 23.1 | 12.0 | 11.1 | 10.2 |
| Yes, both respondent and someone else in hh purchased | 6.7 | 14.3 | 12.8 | 16.2 | 23.9 | 32.4 | 0 | -- | 7.7 | 15.7 | 14.8 | 22.3 |
| No one in hh purchased | 60.0 | 42.9 | 24.8 | 18.8 | 13.6 | 8.8 | 0 | -- | 23.1 | 27.7 | 18.5 | 21.1 |
| Don't know | 0 | 0 | 0 | 0 | 0 | 2.9 | 0 | -- | 0 | 0 | 0 | .6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q2b. In the past year, have you or anyone in your household purchased any cold and flu products such as Comtrex, TheraFlu, Robitussin, or Vicks?** | | | | | | | | | | | | |
| Yes, respondent purchased | 13.3 | 28.6 | 27.1 | 25.6 | 18.2 | 23.5 | 100.0 | 0 | 23.1 | 24.1 | 23.7 | 24.7 |
| Yes, someone else in hh purchased | 0 | 9.5 | 4.5 | 6.8 | 3.4 | 0 | 0 | 0 | 15.4 | 6.0 | 3.7 | 3.0 |
| Yes, both respondent and someone else in hh purchased | 0 | 4.8 | 4.5 | 9.4 | 9.1 | 14.7 | 0 | 0 | 3.8 | 8.4 | 6.7 | 8.4 |
| No one in hh purchased | 86.7 | 57.1 | 63.9 | 58.1 | 67.0 | 55.9 | 0 | 100.0 | 57.7 | 60.2 | 65.2 | 62.7 |
| Don't know | 0 | 0 | 0 | 0 | 2.3 | 5.9 | 0 | 0 | 0 | 1.2 | .7 | 1.2 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q2c. In the past year, have you or anyone in your household purchased any allergy products such as Benadryl, Chlor-Trimeton, Dristoral, Sine-Off, Sinutab, or Tranimine?** | | | | | | | | | | | | |
| Yes, respondent purchased | 0 | 9.5 | 26.3 | 26.5 | 25.0 | 32.4 | 0 | 0 | 11.5 | 20.5 | 25.9 | 27.7 |
| Yes someone in hh purchased | 6.7 | 0 | 4.5 | 8.5 | 4.5 | 11.8 | 0 | 0 | 11.5 | 7.2 | 4.4 | 6.0 |
| Yes, both respondent and someone else in hh purchased | 0 | 9.5 | 4.5 | 7.7 | 9.1 | 11.8 | 0 | 0 | 0 | 7.2 | 6.7 | 8.4 |
| No one in hh purchased | 93.3 | 76.2 | 64.7 | 57.3 | 61.4 | 44.1 | 100.0 | 100.0 | 76.9 | 65.1 | 63.0 | 57.2 |
| Don't know | 0 | 4.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | .6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q2d. In the past year, have you or anyone in your household purchased any other products like these?** | | | | | | | | | | | | |
| Yes, respondent purchased | 0 | 4.8 | 4.5 | 4.3 | 2.3 | 5.9 | 0 | 0 | 0 | 1.2 | 5.2 | 4.8 |
| Yes, someone else in hh purchased | 0 | 4.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | .6 |
| Yes, both respondent and someone else in hh purchased | 0 | 0 | 0 | 1.7 | 0 | 0 | 0 | 0 | 0 | 0 | .7 | .6 |
| No one in hh purchased | 100.0 | 90.5 | 95.5 | 93.2 | 97.7 | 91.2 | 100.0 | 100.0 | 100.0 | 97.6 | 94.1 | 93.4 |
| Don't know | 0 | 0 | 0 | .9 | 0 | 2.9 | 0 | 0 | 0 | 1.2 | 0 | .6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Summary of Q2a-Q2d. Any household purchase of any nasal congestion, cold, flu, or allergy medications?** | | | | | | | | | | | | |
| Yes, household purchased at least one of these medications | 46.7 | 71.4 | 82.7 | 86.3 | 88.6 | 94.1 | 100.0 | 0 | 84.6 | 80.7 | 84.4 | 84.9 |
| No household purchase of any of these medications | 53.3 | 28.6 | 17.3 | 13.7 | 11.4 | 5.9 | 0 | 100.0 | 15.4 | 19.3 | 15.6 | 15.1 |
| **Q3. At which type of store does your household MOST OFTEN buy these types of medications?** | | | | | | | | | | | | |
| Retail or dept. stores | 14.3 | 53.3 | 58.2 | 46.5 | 37.2 | 43.8 | 0 | -- | 59.1 | 55.2 | 55.3 | 35.5 |
| Drug stores | 42.9 | 20.0 | 25.5 | 28.7 | 37.2 | 37.5 | 100.0 | -- | 27.3 | 25.4 | 21.9 | 40.4 |
| Hospital or clinic pharmacies | 14.3 | 0 | 1.8 | 1.0 | 0 | 0 | 0 | -- | 0 | 1.5 | 1.8 | .7 |
| Convenience stores | 0 | 0 | 0 | 0 | 1.3 | 0 | 0 | -- | 0 | 0 | 0 | .7 |
| Grocery stores | 14.3 | 13.3 | 8.2 | 16.8 | 17.9 | 6.3 | 0 | -- | 0 | 7.5 | 14.9 | 16.3 |
| Some other retail store | 14.3 | 6.7 | 0 | 2.0 | 0 | 0 | 0 | -- | 4.5 | 1.5 | 0 | 1.4 |
| Buy from several places | 0 | 6.7 | 4.5 | 5.0 | 6.4 | 12.5 | 0 | -- | 9.1 | 7.5 | 5.3 | 5.0 |
| Some other place [specify] | 0 | 0 | .9 | 0 | 0 | 0 | 0 | -- | 0 | 1.5 | 0 | 0 |
| Don't know | 0 | 0 | .9 | 0 | 0 | 0 | 0 | -- | 0 | 0 | .9 | 0 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q4. When those types of medications are purchased by you or others in your household, how MANY packages or bottles are usually purchased at any one time?** | | | | | | | | | | | | |
| 1 package/bottle | 71.4 | 86.7 | 92.7 | 93.1 | 97.4 | 93.8 | 0 | -- | 86.4 | 92.5 | 92.1 | 95.0 |
| 2 packages/bottles | 0 | 6.7 | 2.7 | 5.9 | 2.6 | 6.3 | 0 | -- | 9.1 | 6.0 | 4.4 | 2.1 |
| 3 packages/bottles | 14.3 | 0 | .9 | 0 | 0 | 0 | 0 | -- | 0 | 0 | .9 | .7 |
| 4 packages/bottles | 14.3 | 0 | 0 | 0 | 0 | 0 | 0 | -- | 0 | 0 | .9 | 0 |
| 5 packages/bottles | 0 | 6.7 | 0 | 0 | 0 | 0 | 0 | -- | 0 | 0 | 0 | .7 |
| Don't know | 0 | 0 | 3.6 | 1.0 | 0 | 0 | 100.0 | -- | 4.5 | 1.5 | 1.8 | 1.4 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q5. How OFTEN would you say someone in your household usually buys these types of medications? Would you say:** | | | | | | | | | | | | |
| Weekly | 0 | 0 | .9 | 1.0 | 1.3 | 0 | 0 | -- | 0 | 0 | 1.8 | .7 |
| Monthly | 0 | 6.7 | 3.6 | 9.9 | 3.8 | 12.5 | 100.0 | -- | 0 | 6.0 | 7.0 | 7.8 |
| Most months/year [6 or more months] | 0 | 0 | 9.1 | 7.9 | 11.5 | 6.3 | 0 | -- | 18.2 | 4.5 | 9.6 | 7.8 |
| Few times/year [1-5 months] | 71.4 | 86.7 | 70.0 | 71.3 | 73.1 | 78.1 | 0 | -- | 63.6 | 74.6 | 68.4 | 75.9 |
| Less than once a year | 28.6 | 6.7 | 14.5 | 9.9 | 9.0 | 3.1 | 0 | -- | 13.6 | 14.9 | 13.2 | 6.4 |
| Don't know | 0 | 0 | 1.8 | 0 | 1.3 | 0 | 0 | -- | 4.5 | 0 | 0 | 1.4 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q6. In Iowa and elsewhere, some people are removing the pseudoephedrine from these medications to manufacture methamphetamine, commonly known as meth. Have you ever heard that this was happening?** | | | | | | | | | | | | |
| Yes | 33.3 | 23.8 | 48.1 | 59.8 | 54.5 | 58.8 | 0 | 0 | 53.8 | 51.8 | 57.8 | 46.4 |
| No | 60.0 | 76.2 | 48.9 | 40.2 | 44.3 | 41.2 | 100.0 | 100.0 | 42.3 | 45.8 | 42.2 | 51.8 |
| Don't know | 6.7 | 0 | 3.0 | 0 | 1.1 | 0 | 0 | 0 | 3.8 | 2.4 | 0 | 1.8 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q7. Do you think the manufacture of meth using pseudoephedrine is a major problem, a minor problem, or not a problem at all?** | | | | | | | | | | | | |
| Major problem | 53.3 | 38.1 | 48.9 | 49.6 | 53.4 | 52.9 | 0 | 100.0 | 53.8 | 48.2 | 49.6 | 50.6 |
| Minor problem | 0 | 14.3 | 10.5 | 13.7 | 11.4 | 17.6 | 0 | 0 | 19.2 | 9.6 | 11.9 | 12.0 |
| Not a problem | 0 | 4.8 | 3.0 | 6.0 | 4.5 | 0 | 100.0 | 0 | 3.8 | 2.4 | 5.2 | 4.2 |
| Don't know | 46.7 | 42.9 | 37.6 | 30.8 | 30.7 | 29.4 | 0 | 0 | 23.1 | 39.8 | 33.3 | 33.1 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q8a. How much of an inconvenience to you would it be if people were limited in the quantity of these medications they could buy at one time?** | | | | | | | | | | | | |
| Large inconvenience | 0 | 14.3 | 4.5 | 3.4 | 4.5 | 5.9 | 0 | 0 | 0 | 6.0 | 2.2 | 6.6 |
| Moderate inconvenience | 0 | 9.5 | 9.8 | 6.8 | 9.1 | 5.9 | 0 | 0 | 7.7 | 3.6 | 13.3 | 6.0 |
| Small inconvenience | 13.3 | 19.0 | 21.8 | 21.4 | 12.5 | 14.7 | 0 | 100.0 | 19.2 | 20.5 | 17.0 | 19.3 |
| Not an inconvenience at all | 73.3 | 47.6 | 63.2 | 65.0 | 72.7 | 73.5 | 100.0 | 0 | 73.1 | 69.9 | 64.4 | 64.5 |
| Don't know | 13.3 | 9.5 | .8 | 3.4 | 1.1 | 0 | 0 | 0 | 0 | 0 | 3.0 | 3.6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q8b. How much of an inconvenience to you would it be if people had to show a photo ID to buy them?** | | | | | | | | | | | | |
| Large inconvenience | 13.3 | 4.8 | 6.0 | 7.7 | 6.8 | 11.8 | 0 | 0 | 3.8 | 7.2 | 8.1 | 7.2 |
| Moderate inconvenience | 6.7 | 9.5 | 10.5 | 8.5 | 5.7 | 11.8 | 0 | 0 | 3.8 | 4.8 | 8.1 | 12.0 |
| Small inconvenience | 13.3 | 23.8 | 12.0 | 17.1 | 18.2 | 14.7 | 0 | 0 | 23.1 | 13.3 | 14.1 | 16.9 |
| Not an inconvenience at all | 60.0 | 47.6 | 71.4 | 65.0 | 69.3 | 61.8 | 100.0 | 100.0 | 61.5 | 74.7 | 68.1 | 62.7 |
| Don't know | 6.7 | 14.3 | 0 | 1.7 | 0 | 0 | 0 | 0 | 7.7 | 0 | 1.5 | 1.2 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q8c. How much of an inconvenience to you would it be if people had to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Large inconvenience | 6.7 | 14.3 | 6.8 | 5.1 | 10.2 | 11.8 | 0 | 0 | 3.8 | 7.2 | 5.9 | 10.2 |
| Moderate inconvenience | 6.7 | 14.3 | 14.3 | 11.1 | 20.5 | 17.6 | 0 | 0 | 15.4 | 10.8 | 14.1 | 16.9 |
| Small inconvenience | 20.0 | 14.3 | 13.5 | 23.9 | 13.6 | 11.8 | 0 | 0 | 15.4 | 14.5 | 14.1 | 19.9 |
| Not an inconvenience at all | 60.0 | 47.6 | 63.2 | 59.8 | 55.7 | 58.8 | 100.0 | 100.0 | 65.4 | 65.1 | 63.7 | 52.4 |
| Don't know | 6.7 | 9.5 | 2.3 | 0 | 0 | 0 | 0 | 0 | 0 | 2.4 | 2.2 | .6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q9a. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people were limited in the quantity of these medications they could buy at one time?** | | | | | | | | | | | | |
| Very effective | 40.0 | 9.5 | 20.3 | 14.5 | 17.0 | 11.8 | 0 | 0 | 7.7 | 20.5 | 20.2 | 15.1 |
| Moderately effective | 6.7 | 4.8 | 23.3 | 29.1 | 21.6 | 17.6 | 0 | 100.0 | 15.4 | 21.7 | 26.7 | 21.1 |
| Somewhat effective | 13.3 | 19.0 | 32.3 | 26.5 | 33.0 | 20.6 | 0 | 0 | 38.5 | 21.7 | 26.7 | 31.3 |
| Not at all effective | 33.3 | 38.1 | 7.5 | 23.9 | 15.9 | 38.2 | 100.0 | 0 | 15.4 | 22.9 | 17.0 | 19.9 |
| Don't know | 6.7 | 23.8 | 16.5 | 6.0 | 12.5 | 11.8 | 0 | 0 | 23.1 | 12.0 | 9.6 | 12.7 |
| Refused | 0 | 4.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1.2 | 0 | 0 |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q9b. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to show a photo-ID to buy them?** | | | | | | | | | | | | |
| Very effective | 40.0 | 19.0 | 26.3 | 22.2 | 18.2 | 20.6 | 100.0 | 0 | 11.5 | 25.3 | 23.7 | 23.5 |
| Moderately effective | 13.3 | 23.8 | 30.8 | 27.4 | 23.9 | 17.6 | 0 | 0 | 26.9 | 30.1 | 28.9 | 21.7 |
| Somewhat effective | 20.0 | 9.5 | 26.3 | 22.2 | 23.9 | 26.5 | 0 | 100.0 | 42.3 | 19.3 | 19.3 | 26.5 |
| Not at all effective | 26.7 | 33.3 | 8.3 | 22.2 | 21.6 | 29.4 | 0 | 0 | 11.5 | 16.9 | 19.3 | 20.5 |
| Don't know | 0 | 14.3 | 8.3 | 6.0 | 12.5 | 5.9 | 0 | 0 | 7.7 | 8.4 | 8.9 | 7.8 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q9c. How effective at reducing the manufacture of meth using pseudoephedrine do you think it would be if people had to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Very effective | 40.0 | 14.3 | 36.1 | 24.8 | 26.1 | 23.5 | 100.0 | 0 | 26.9 | 25.3 | 30.4 | 29.5 |
| Moderately effective | 13.3 | 19.0 | 29.3 | 30.8 | 29.5 | 26.5 | 0 | 100.0 | 26.9 | 32.5 | 31.1 | 24.7 |
| Somewhat effective | 20.0 | 9.5 | 19.5 | 20.5 | 22.7 | 14.7 | 0 | 0 | 19.2 | 19.3 | 19.3 | 19.9 |
| Not at all effective | 20.0 | 33.3 | 5.3 | 19.7 | 12.5 | 26.5 | 0 | 0 | 19.2 | 14.5 | 11.9 | 16.3 |
| Don't know | 6.7 | 23.8 | 9.8 | 4.3 | 9.1 | 8.8 | 0 | 0 | 7.7 | 8.4 | 7.4 | 9.6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q10a. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose limiting the quantity of these medications that can be bought at any one time?** | | | | | | | | | | | | |
| Strongly support | 60.0 | 23.8 | 49.6 | 51.3 | 50.0 | 44.1 | 0 | 0 | 50.0 | 60.2 | 47.4 | 43.4 |
| Moderately support | 20.0 | 38.1 | 30.1 | 32.5 | 37.5 | 44.1 | 0 | 0 | 30.8 | 30.1 | 34.1 | 34.9 |
| Moderately oppose | 13.3 | 23.8 | 9.0 | 6.0 | 5.7 | 5.9 | 0 | 100.0 | 15.4 | 3.6 | 9.6 | 8.4 |
| Strongly oppose | 0 | 9.5 | 3.0 | 5.1 | 1.1 | 5.9 | 100.0 | 0 | 0 | 1.2 | 3.0 | 6.6 |
| Don't know/No opinion | 6.7 | 4.8 | 8.3 | 5.1 | 5.7 | 0 | 0 | 0 | 3.8 | 4.8 | 5.9 | 6.6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

| Question | Education Level | | | | | | | | County Type | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1st – 8th grade | 9th – 11th grade | Grade 12 or GED | College 1 – 3 years | College 4 years or more | Graduate degree completed | Don't know | Refused | Rural | Mostly rural | Mostly Urban | Urban |
| **Q10b. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring a photo-ID to be shown to buy them?** | | | | | | | | | | | | |
| Strongly support | 60.0 | 42.9 | 51.9 | 43.6 | 48.9 | 41.2 | 0 | 0 | 38.5 | 56.6 | 47.4 | 44.6 |
| Moderately support | 20.0 | 23.8 | 28.6 | 37.6 | 29.5 | 35.3 | 100.0 | 100.0 | 34.6 | 30.1 | 29.6 | 33.7 |
| Moderately oppose | 6.7 | 14.3 | 6.8 | 5.1 | 10.2 | 14.7 | 0 | 0 | 19.2 | 6.0 | 8.1 | 7.2 |
| Strongly oppose | 6.7 | 14.3 | 3.8 | 8.5 | 4.5 | 5.9 | 0 | 0 | 0 | 2.4 | 7.4 | 7.8 |
| Don't know/No opinion | 6.7 | 4.8 | 9.0 | 5.1 | 6.8 | 2.9 | 0 | 0 | 7.7 | 4.8 | 7.4 | 6.6 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Q10c. Would you say you strongly support, moderately support, moderately oppose, or strongly oppose requiring one to ask a pharmacist or clerk for them?** | | | | | | | | | | | | |
| Strongly support | 66.7 | 38.1 | 48.1 | 47.0 | 53.4 | 32.4 | 0 | 0 | 42.3 | 56.6 | 48.1 | 43.4 |
| Moderately support | 13.3 | 19.0 | 28.6 | 34.2 | 30.7 | 41.2 | 100.0 | 100.0 | 38.5 | 27.7 | 29.6 | 32.5 |
| Moderately oppose | 6.7 | 19.0 | 10.5 | 6.8 | 10.2 | 11.8 | 0 | 0 | 7.7 | 9.6 | 8.9 | 10.8 |
| Strongly oppose | 6.7 | 14.3 | 4.5 | 6.0 | 2.3 | 11.8 | 0 | 0 | 7.7 | 1.2 | 5.2 | 7.8 |
| Don't know/No opinion | 6.7 | 9.5 | 8.3 | 6.0 | 3.4 | 2.9 | 0 | 0 | 3.8 | 4.8 | 8.1 | 5.4 |
| Refused | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

655 15TH STREET, N.W., SEVENTH FLOOR
WASHINGTON, D.C. 20005-5701
TELEPHONE: 202/452-8444
FAX: 202/220-0873
E-MAIL: FMI@FMI.ORG
WEBSITE: WWW.FMI.ORG

November 1, 2004

The Honorable Mark Souder
Chairman
House Government Reform Subcommittee
on Criminal Justice, Drug Policy & Human Resources
B-373B Rayburn House Office Building
Washington, D. C. 20515

Dear Chairman Souder:

The Food Marketing Institute (FMI), on behalf of our member companies who are operating approximately 26,000 retail food stores throughout the United States, wishes to express our industry's strong support for legislation (H.R. 5347) that you have introduced which would eliminate the safe-harbor exemption for Over-The-Counter (OTC) drug products that contain pseudoephedrine.

We believe that your initiative, which calls for a national threshold of 6 grams, strikes the correct balance allowing consumers to purchase a sufficient amount of medication for the purpose of treating a cough or cold while complimenting current efforts to reduce the illegal use of pseudoephedrine. Moreover, this new threshold sales limit, as specified in H.R. 5347, will remedy a disparity in the law between products that are packaged in bottles which are subjected to a 9 gram threshold and products that come in blister-packs which are currently not subjected to any sales limitation. Because your proposal provides for national uniformity governing the sale of pseudoephedrine products, it will promote greater compliance among the retail community, especially in terms of larger companies that operate stores in multiple states. Additionally, H. R. 5347 has a grandfather provision and will not pre-empt state retail sales restriction laws that were enacted prior to January 1, 2005.

FMI commends you for your leadership efforts against the diversion of pseudoephedrine products which are used for the illegal purpose of manufacturing methamphetamine. In expressing our industry's support for H. R. 5347, FMI looks forward to working with you toward enactment of this critically needed initiative.

Sincerely,

John J. Motley III
Senior Vice President
Government and Public Affairs

YOUR NEIGHBORHOOD SUPERMARKETS

Printed on recycled paper

NOV.01.2004 11:24 202 220 0874 FMI #2425 P.002/002

**EMBARGOED FOR RELEASE**
**AT NOON ON NOVEMBER 18, 2004**

Contact: Bill Greer
202-220-0667
wgreer@fmi.org

**FMI Testimony:**

## Food Retailers Support Constraints on Sales of Cold Medicines Used to Create Methamphetamine — But Not Removing Them From Store Shelves

***Industry Calls For Alternative Solutions to Combat Meth Production***

WASHINGTON, DC — November 18, 2004 — As if the flu vaccine shortage weren't enough to give people headaches, new government limits on the sales of hundreds of cough and cold remedies could trigger migraines, according to testimony today by the Food Marketing Institute (FMI) before the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources.

At issue is an Oklahoma law, which other states and the federal government are considering, that requires these products to be removed from store shelves and sold only by pharmacies by reclassifying them as Schedule V drugs under controlled substances laws. The intent is to restrict sales of products containing pseudoephedrine used to create methamphetamine. The products affected include such common names as Actifed, Allerest, Nyquil, Sinutab, Sudafed and Tylenol Allergy Sinus.

Testifying on behalf of the industry and FMI, Marsh Supermarkets Senior Vice President of Government Affairs Joseph Heerens emphasized that the industry strongly supports sales restrictions on such cold and cough remedies. "But a Schedule V approach is very troublesome. That's because the overwhelming majority of grocery stores in the United States do not have a pharmacy department.

"For example, my company currently operates approximately 120 supermarkets in Indiana and Ohio, but only 46 of them have a pharmacy department. Therefore, under the Oklahoma model, more than 60 percent of our stores could not sell the pseudoephedrine products that our customers expect us to carry."

Nationwide, only about 15,000 of the more than 210,000 retail food stores have pharmacies, according to industry data — meaning that if the Oklahoma law were adopted nationally, consumers could not buy cough and cold products at nearly 200,000 outlets, ranging from convenience stores to conventional supermarkets.

- more -

Even in stores with pharmacies, Hereens noted that the availability of such products would be limited by store hours and space limits in the pharmacy department. "Our pharmacy departments are typically open less than 12 hours per day," he testified. And owing to lack of space in the pharmacy, the number of cough and cold products carried would have to be reduced from more than 150 "to no more than a few dozen."

Instead of using Schedule V to control the sales of products used to create methamphetamine, he said, the industry advocates a more comprehensive strategy and partnership among law enforcement, regulatory agencies, manufacturers and retailers.

Specifically, the industry supports tighter constraints on purchases of such products. Under current law, consumers may purchase nine grams of the product at a single time, while those sold in blister packs are exempt from this restriction. The industry supports lowering the sales limit to six grams and eliminating the exemption, he said. In addition, the industry and FMI advocate:

- Greater regulatory authority, controls, tracking and quota limits over imports and the sale of bulk chemicals of ephedrine and pseudoephedrine.
- A ban on Internet sales of chemicals used to create methamphetamine.
- Promotion and funding of educational training programs for store employees concerning suspicious pseudoephedrine purchases, such as the Meth Watch Program (www.MethWatch.com).
- Stiffer penalties for the manufacturing, distribution and possession of methamphetamine.
- Greater federal regulatory authority, including licensing and inspection at the distributor level, especially secondary wholesalers.

# # #

Food Marketing Institute (FMI) conducts programs in research, education, industry relations and public affairs on behalf of its 1,500 member companies — food retailers and wholesalers — in the United States and around the world. FMI's U.S. members operate approximately 26,000 retail food stores with a combined annual sales volume of $340 billion — three-quarters of all food retail store sales in the United States. FMI's retail membership is composed of large multi-store chains, regional firms and independent supermarkets. Its international membership includes 200 companies from 50 countries.

**Statement of Congressman Rick Larsen**

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

10:00a.m., Thursday, December 2, 2004,

Room 2154

On Methamphetamine Trafficking

Chairman Souder and members of the subcommittee:

Thank you for holding this hearing on how we can best assist state and local law enforcement agencies in combating the growing problem of methamphetamine. As Co-Chair of the Congressional Caucus to Fight and Control Methamphetamine, I ardently believe that the use of methamphetamine is a growing problem, one that has devastating affects on urban and rural communities. Preventative measures must be implemented to reduce demand and consumption of methamphetamine and state and local communities must be given resources to prepare them to fight and win the war on meth.

Methamphetamine, whether referred to as: Speed, Ice, Chalk, Crank, Fire, Glass, Crystal or just plain meth is among the fastest growing drug problems throughout the nation, and must be addressed as such.

Meth is highly addictive and can be easily made. The recipe to manufacture meth can be obtained over the Internet, and many of the ingredients are common household products, which can be purchased at a local drug or grocery store. Consequently, more than two-thirds of meth labs are found in "average" residences in rural areas and a startling 12% of America's youth have used meth.

Local meth production leaves behind five to six pounds of toxic waste per pound of meth produced. The proliferation of meth labs has led to an increasingly large number of drug-endangered children who have been exposed to these dangerous toxins, as well as the first responders who unknowingly stumble upon a lab. The clean-up costs of these meth labs are very resource-intensive and beyond the capabilities of most jurisdictions. The average cost of a cleanup is about $5,000, but some cost as much as $150,000.

Meth is obviously a threat to our communities. And thus, it will take a community solution to take control of this epidemic. As Co-Chair of the Meth Caucus, I believe Congress must work towards increased funding to assist states with law enforcement training and resources. In addition, the needs of drug endangered children, clean up and disposal of meth labs, health care costs such as treatment and prevention efforts, and social services need to be concentrated on. We need to help our community coalitions enable themselves to rid their neighborhoods of meth and keep meth off their streets.

As we approach a new year, it is time for federal agencies to look at what efforts they have underway to fight meth and what additional efforts are needed as this epidemic increases in the future. One factor benefiting the fight against meth is that virtually every ingredient passes through a regulated institution such as a pharmacy, hardware store or grocery store. The supply

of two key ingredients comes from nine factories in only four countries. The federal government needs to do much more to keep these chemicals out of the hands of criminals.

The accomplishment of winning the fight against meth will take a partnership between retailers, law enforcement agencies and local communities. One such partnership is a program called Meth Watch, similar to the We ID or We Card programs where employers and employees are trained on how to keep meth precursors under tighter security, and are trained on what to do when individuals are acting suspiciously.

Currently, the vast majority of federal funds used to combat our nation's meth problem are allocated for *supply* reduction strategies, such as law enforcement efforts that contend with preventing precursor chemicals from entering the U.S. These funds are inefficient and currently inadequate. The Office of National Drug Control Policy (ONDCP), the Drug Enforcement Administration (DEA), the Department of Justice (DOJ), and the National Guard need appropriate resources and funding to be effective assisting in the fight against meth. I have been disappointed by the lack of focus many agencies give to meth when it is clear it may have the highest national impact of any illicit drug.

In addition, little has been done to effectively cut *demand* for meth, and as long as demand remains unaddressed the use of this dangerous illegal drug will continue spreading across the United States. The federal government needs to be move forward with a reduction effort that parallels that of marijuana. A greater emphasis needs to be placed on reducing consumer demand for this drug through a media-based education campaign targeting consumers, especially teenagers and young adults.

Another proactive step that needs to be taken is the establishment of a national database or clearinghouse for resources to help communities fight meth. This clearinghouse would allow local communities and law enforcement agencies to access information and additional resources on the best practices to combat the effects of meth; allowing states to learn from the lessons of other states.

Meth is a serious and major threat; it is imperative that federal agencies view it as such. Through persistence and partnerships this is a fight we can and must win.

I look forward to working with you, Chairman Souder, and the Government Reform Committee to help increase the role of our federal agencies and our federal resources in the fight against meth. Thank you, Mr. Chairman.

**Statement by Congressman Greg Walden**

**November 18, 2004**
**Subcommittee Criminal Justice,**
**Drug Policy and Human Resources**

**Hearing on Law Enforcement and the**
**Fight Against Methamphetamine**

Mr. Chairman, thank you for the opportunity to address the Subcommittee on this critical issue.

The rampant increase in methamphetamine ("meth") production, trafficking and abuse in recent years is cause for concern throughout the entire United States, especially in my home state of Oregon.

With just over one percent of the nation's population, Oregon produced over seven percent of all admissions for substance abuse treatment throughout the country; and the drug is now second only to alcohol for such admissions in the state.

Oregon's children suffer tremendously with the rising production and abuse of meth, and they consequently run the risk of becoming complacent toward its destructiveness. In Oregon, there has been a 57% increase in the number of female youth treated for meth and a 23% increase in male youth since 1999. In 2003, there were 54 methamphetamine lab sites in Oregon in which a child was present, living and breathing the harsh reality of meth production, use and trafficking.

In addition to use, the production of meth has become an increasingly devastating reality for communities throughout the state. From the Portland metropolitan area in the north to Medford in the south, meth labs have sprouted in every corner of Oregon.

But the problem is not merely rooted in our urban areas. Its talons have reached into smaller, more rural regions where ingredients can be found, production is less detectable and there are arterial traffic routes and waterways for distribution.

Perhaps no region in Oregon understands this issue more starkly than Umatilla County. Per capita, Umatilla County has a far greater number of meth lab seizures than any other county in Oregon. Of the 454 methamphetamine labs seized throughout Oregon in 2003, 13% of them were in Umatilla County, an area with only two percent of the state's population. Their portion has jumped to 21% so far this year.

Why is Oregon such a haven for meth production and trafficking?

With rural Oregon's rich base in agriculture comes easy accessibility to anhydrous ammonia, a widely used source of nitrogen for crop production and a key ingredient in the production of meth. The booming housing markets in southern and central Oregon provide manufacturers with plenty of construction sites from which to steal equipment and material for their labs. And Oregon's dense forests, steep mountainsides and sparsely populated regions provide "cooks" with the ability to set up labs in areas that cannot sustain law enforcement crews necessary to root them out.

Additionally, meth manufacturers enjoy interstate highway and waterway systems that give Oregon the unfortunate ability to become a transshipment point of illegal drugs throughout the west. Northeast Oregon has a talented law enforcement team working overtime trying to keep up with all of the activity in the region.

In Oregon's fight against meth, we are fortunate to have the support of educational efforts like Oregon Partnership, an organization that works with community coalitions and schools. Oregon Partnership, under the direction of Chief Executive Officer Judy Cushing, has partnered with local radio and TV stations to publicize the dangers of meth and meth production labs, created public service announcements for media outlets to run, and filmed a documentary targeting teenagers to be shown in schools.

I have written to the chairman of the Appropriations Subcommittee on Commerce, Justice, State and the Judiciary urging support for funding of the critical methamphetamine prevention program being implemented by Oregon Partnership. They have done a great deal to broaden public awareness about this issue, and for that Oregonians are grateful.

Unfortunately, it is not enough. We must combat this problem from all angles.

As indicated in a bipartisan letter I signed written to the Drug Enforcement Agency (DEA), I believe that there must be a comprehensive review of the nation's precursor control laws and programs. Additionally, I am supportive of increased funding for the national Drug-Free Communities Act and the National Youth Anti Drug Media Campaign, as written in a letter sent to the chairman of the House Appropriations Subcommittee on Transportation, Treasury and General Government.

The fight against meth is one that must be fought as a nation in order to avoid the nomadic tendencies "cooks" will display when one state has less strict laws than another. However, we must continue local, targeted assistance to those areas most affected.

Oregon is in desperate need of additional assistance for its many communities fighting the battle against methamphetamines. Umatilla County, which faces the worst of our state's meth and marijuana problems, has been denied a High Intensity Drug Trafficking Area (HIDTA) designation. I reiterate my request that Umatilla County be designated as a HIDTA given its ideal conditions for production and its proximity to the Columbia River Channel, the Pacific Ocean, Interstate 84, Washington, Idaho, Montana and Canada.

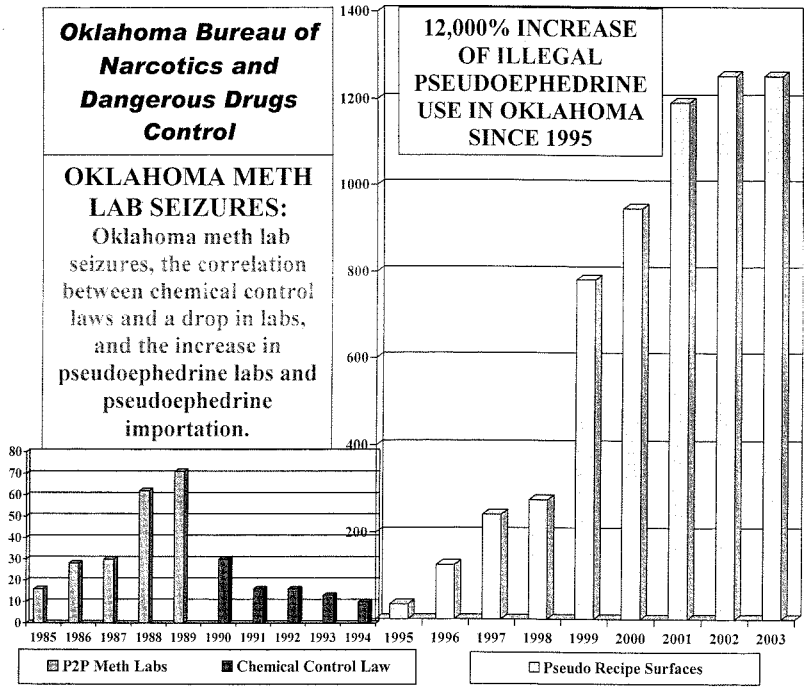
Just a few months ago, Scott Burns, deputy director for the Office of National Drug Control Policy, joined me in Pendleton, Oregon for a meeting with the Blue Mountain Enforcement Narcotics Team (BENT), a coalition of law enforcement officials from Umatilla and surrounding counties working collaboratively to fight our rising drug problem. Sheriff John Trumbo and Sergeant Greg Sherman from Umatilla County, Sheriff Verlin Denton and Sergeant Mark Miller of Morrow County, and others gave a startling description of the scope they face when it comes to the problems of meth, marijuana and other drugs in Eastern Oregon. They are doing a tremendous job and their work is invaluable, but they are stretched far too thin.

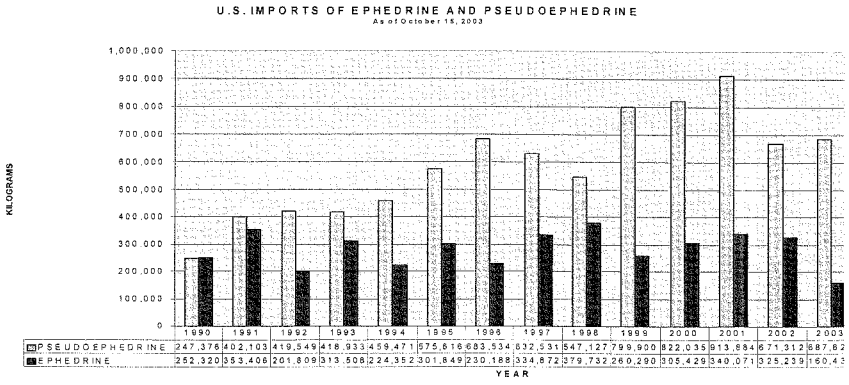
Due to BENT's limited financial and human resources, the unit's ability to target mid- and upper-level drug trafficking organizations in the region will continue to be severely constrained without additional help. Increased DEA assistance to the region through the establishment of a permanent field office in Pendleton will provide BENT and other law enforcement entities enhanced abilities to fight the growing problem posed not only by meth, but also marijuana and other drugs.

In order to successfully fight the scourge of methamphetamines, communities – parents, law enforcement, educators, and business leaders – must come together. Preventing both the use and production of meth is paramount to the public safety and health of our schools, cities and states nationwide.

Oregon is working hard to fight this rampant problem facing both urban and rural areas. Mr. Chairman, I look forward to working with you and the rest of our colleagues in Congress to find solutions to this emergency. I also look forward to working with representatives from federal agencies and departments and the terrific people at home in Oregon as we fight to take back our communities from this menacing drug.

Thank you.


Oklahoma Bureau of Narcotics and Dangerous Drugs Control
OKLAHOMA METH LAB SEIZURES:
Oklahoma meth lab seizures, the correlation between chemical control laws and a drop in labs, and the increase in pseudoephedrine labs and pseudoephedrine importation.
12,000% INCREASE OF ILLEGAL PSEUDOEPHEDRINE USE IN OKLAHOMA SINCE 1995
1400
1200
1000
800
600
400
200
80
70
60
50
40
30
20
10
0
1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003
P2P Meth Labs
Chemical Control Law
Pseudo Recipe Surfaces


U.S. IMPORTS OF EPHEDRINE AND PSEUDOEPHEDRINE
As of October 15, 2003
KILOGRAMS
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003
PSEUDOEPHEDRINE 247,376 402,103 419,549 418,933 459,471 575,616 683,534 632,531 547,127 799,900 822,035 913,884 671,312 687,62
EPHEDRINE 252,320 353,406 201,809 313,508 224,352 301,849 230,188 334,872 379,732 260,290 305,429 340,071 325,239 160,43
YEAR

# *Pre and Post HB 2176*
# *Meth Lab Stats*

*Includes Oklahoma City P.D., Tulsa P.D. and OSBI Labs*

## *Oklahoma City P.D.*

| 2004 by Month | | (2003) |
|---|---|---|
| January | 15 | (20) |
| February | 17 | (17) |
| March | 13 | (15) |
| *April* | *9* | *(17)* |
| *May* | *6* | *(12)* |
| *June* | *6* | *(15)* |
| *July* | *7* | *(13)* |
| *August* | *5* | *(12)* |
| *September* | *2* | *(12)* |
| *October* | *4* | *(14)* |
| *Total:* | *84* | *(147)* |

**2003 Total Labs: 175 or 14.5 per month**
Since April 1st, 2004, OCPD is averaging 5.5 a month, a pace of 66 labs over a full year.

## *Tulsa P.D.*

| 2004 by Month | | (2003) |
|---|---|---|
| January | 22 | (23) |
| February | 19 | (21) |
| March | 17 | (23) |
| *April* | *19* | *(21)* |
| *May* | *13* | *(12)* |
| *June* | *4* | *(14)* |
| *July* | *8* | *(15)* |
| *August* | *8* | *(14)* |
| *September* | *9* | *(14)* |
| *October* | *4* | *(17)* |
| *Total:* | *123* | *(174)* |

**2003 Total Labs: 212 or 17.6 per month**
Since April 1st, 2004, Tulsa P.D. is averaging 9.2 labs a month, a pace of 110 over a full year.

## *OSBI Stats:*

(Includes walk-in's and those worked by an OSBI Chemist
* These figures DO NOT include OCPD and Tulsa PD)

| 2004 by Month | | (2003) |
|---|---|---|
| **January:** | **60** | **(62)** |
| **February:** | **84** | **(127)** |
| **March:** | **100** | **(75)** |
| *April:* | *62* | *(105)* |
| *May:* | *29* | *(66)* |
| *June:* | *50* | *(75)* |
| *July:* | *48* | *(58)* |
| *Total:* | *433* | *(568)* |

**2003 Total Labs: 846 or 70.5 per month.**
**Since April 1st, 2004, OSBI is averaging 47 a month, a pace of 564 for a full year.**

## *Total Meth Lab Seizures:*

***(OSBI, OCPD and Tulsa PD, combined)***

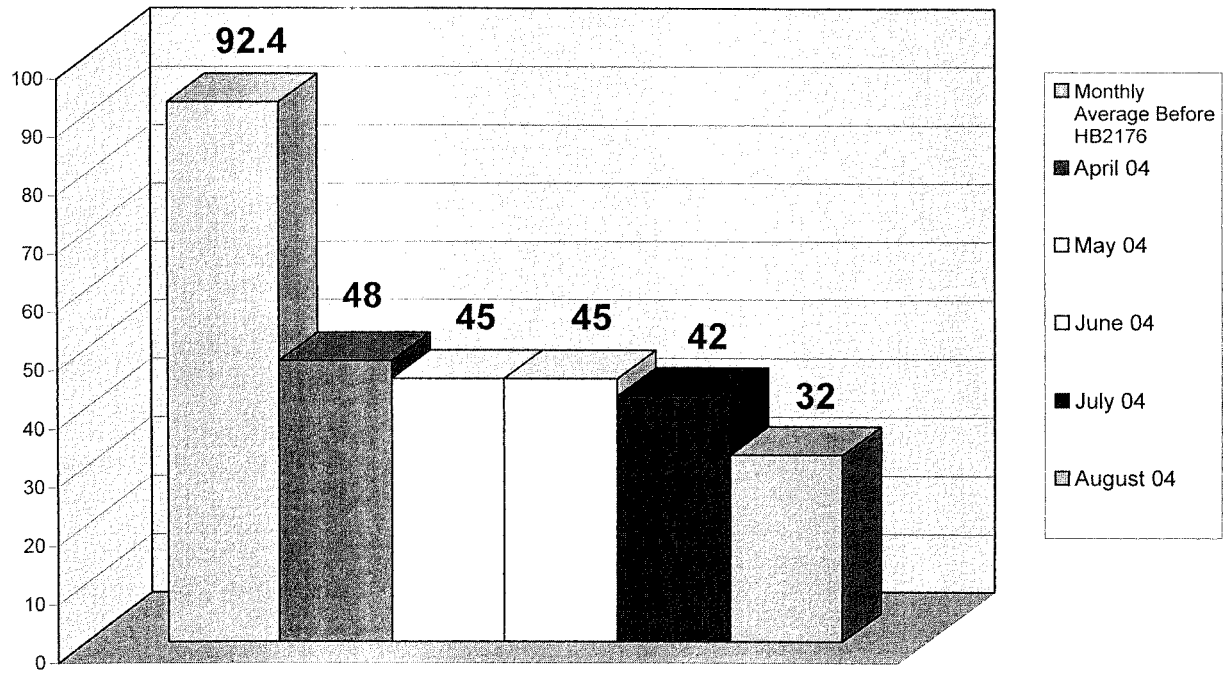
| 2004 by Month | | (2003) |
|---|---|---|
| **January** | **97** | **(105)** |
| **February** | **120** | **(165)** |
| **March** | **130** | **(113)** |
| *April* | *90* | *(143)* |
| *May* | *48* | *(90)* |
| *June* | *62* | *(104)* |
| *July* | *63* | *(86)* |
| *Total:* | *610* | *(806)* |

**In 2003, Oklahoma had 1233 labs, an average of 103 a month. Since April, Oklahoma is averaging 65 a month, a pace for 789 labs over a full year, a drop of 444 labs compared to 2003.**

HB 2176 was signed into law April 6, 2004. The grace period for convenience stores ended May 6, 2004. The grace period for pharmacy compliance ended June 6, 2004. Combining the figures from the OCPD, Tulsa and OSBI labs gives us the total for the state.

## Comparison of Post HB 2176 Months to Previous Monthly Average

**Numbers Reflect Total Lab Cases Per Month For All Task Forces Combined**



**This chart contains legislative information pertaining to state regulation of ephedrine and pseudoephedrine. The scope of this information is limited to existing state statutes and current bills as they relate to precursor chemicals and the prevention of the manufacture of illegal substances, primarily methamphetamine. The chart does not reference those statutes and bills whose sole focus is a related issue, such as criminal possession of an illegal substance or precursor, clandestine lab clean-up, drug-endangered children, etc.**

**As the current state legislative sessions progress, this information will change frequently so please check the chart for regular updates. This chart is intended for educational purposes and you should not act or rely on the information contained herein without first seeking the advice of an attorney within your jurisdiction.**

**Future updates will be posted on the National Alliance for Model State Drug Laws web-site at www.natlalliance.org/publications.asp.**

Descriptions of Table Headings

*State*: Two-letter abbreviation of the US state or district.

*Scheduling*: The state currently lists ephedrine and/or pseudoephedrine as a scheduled controlled substance. Please note that the majority of states that currently schedule ephedrine and or ephedrine have specific exemptions for over-the-counter products. Many of the bills that are being introduced in this legislative session would, among other measures, abolish such exceptions.

*Point of Sale Restrictions*: The state has laws or regulations that place restrictions on pseudoephedrine at the point at which it is sold. These restrictions can include quantity restrictions, packaging restrictions, placement within a store, etc…

*Current Bills*: Draft, Pre-filed or Introduced bills pertaining either to the scheduling of ephedrine/pseudoephedrine or point of sale restrictions for ephedrine/pseudoephedrine.

Links

The links provided within the text of the chart are either to the bills or to the respective state's legislative search engines.

**This information is current as of January 26th, 2005.**

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| AL | Not Scheduled | YES | NONE |
| AK | Not Scheduled | NO | NONE |
| AZ | Ephedrine (Schedule V) | YES | SB 1126 (Introduced 1/18/05): Places point of sale restrictions on ephedrine (http://www.azleg.state.az.us/legtext/47leg/1r/bills/sb1126p%2Epdf) |
| AR | Ephedrine (Schedule V) | YES | SB 109 (Introduced 1/20/05): Places point of sale restrictions on ephedrine & pseudoephedrine and makes pseudoephedrine a Schedule V controlled substance (http://www.arkleg.state.ar.us/ftproot/bills/2005/public/SB109.pdf) |
| CA | Not Scheduled | YES | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| CO | Ephedrine (Schedule II) | NO | HB 1110 (Introduced 1/17/05): Places point of sale restrictions on "methamphetamine precursor drugs" (http://www.leg.state.co.us/) |
| CT | Not Scheduled | NO | NONE |
| DE | Not Scheduled | NO | NONE |
| DC | Not Scheduled | NO | NONE |
| FL | Not Scheduled | NO | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| GA | Not Scheduled | NO | HB 19 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>HB 45 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>SB 24 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>(http://www.legis.state.ga.us/) |
| HI | Not Scheduled | NO | NONE |
| ID | Ephedrine & Pseudoephedrine (Schedule II) | NO | HB 1 (Introduced 1/12/15): Places point of sale restrictions on pseudoephedrine AND makes pseudoephedrine a Schedule V controlled substance<br>(http://www3.state.id.us/oasis/H0001.html) |
| IL | Ephedrine (Schedule IV) | YES | NONE |
| IN | Not Scheduled | NO | HB 1044 (Introduced 1/4/05); SB 444 (Introduced 1/13/05); HB 1685 (Introduced 1/19/05) and SB 588 (Introduced 1/20/05): Place point of sale restrictions on ephedrine & pseudoephedrine<br>HB 1223 (Introduced 1/6/05) and HB 1527 (Introduced 1/18/05): Make ephedrine & pseudoephedrine Schedule V controlled substances<br>(http://www.in.gov/apps/lsa/session/billwatch/billinfo) |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| IA | Ephedrine (Schedule V) | YES | HF 32 (Introduced 1/10/05); SSB 1025 (Introduced 1/19/05) and SSB 1026 (Introduced 1/19/05): Make methamphetamine precursors (including ephedrine & pseudoephedrine) Schedule V controlled substances (http://www.legis.state.ia.us/Legislation.html) |
| KS | Ephedrine (Schedule V) | NO | SB 27 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine and makes ephedrine & pseudoephedrine Schedule V controlled substances (http://www.kslegislature.org/bills/2006/27.pdf) |
| KY | Not Scheduled | NO | SB 56 (Introduced 1/7/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://www.lrc.ky.gov/record/05rs/SB56/bill.doc) |
| LA | Ephedrine & Pseudoephedrine (Schedule II) | YES | NONE |
| ME | Not Scheduled | NO | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| MD | Not Scheduled | NO | NONE |
| MA | Not Scheduled | NO | NONE |
| MI | Ephedrine (Schedule V) | YES | NONE |
| MN | Not Scheduled | NO | HF 4 (Introduced 1/6/05); HF 89 (Introduced 1/10/05); HF 90 (Introduced 1/10/05); HF 364 (Introduced 1/20/05); SF 49 (Introduced 1/6/05); and SF 51 (Introduced 1/6/05): Place point of sale restrictions on ephedrine & pseudoephedrine (http://www.leg.state.mn.us/leg/legis.asp)<br>SF 423 (Introduced 1/20/05): Places point of sale restriction on ephedrine & pseudoephedrine and makes ephedrine & pseudoephedrine Schedule V controlled substances (http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S0423.0&session=ls84) |
| MS | Not Scheduled | NO | SB 2141 (Introduced 1/7/05) ; HB 1527 (Introduced 1/19/05) and HB 1536 (Introduced 1/19/05): Place point of sale restrictions on pseudoephedrine and make pseudoephedrine a Schedule V controlled substance<br>SB 2476 (Introduced 1/14/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>HB 607 (Introduced 1/12/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://billstatus.ls.state.ms.us/2005/pdf/select.htm) |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| MO | Ephedrine (Schedule IV) | YES | SB 10 (Introduced 1/5/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>SB 27 (Introduced 1/5/05): Places point of sale restrictions on ephedrine & pseudoephedrine and makes pseudoephedrine a Schedule V controlled substance<br>HB 167 (Introduced 1/6/05): Places point of sale restrictions on pseudoephedrine<br>(http://www.house.state.mo.us/jointsearch/) |
| MT | Ephedrine (Schedule IV) | NO | MD 1571 (Filed 12/29/04): Places point of sale restrictions on pseudoephedrine<br>(http://data.opi.state.mt.us/bills/2005/lchtml/LC1571.htm)<br>SB 287 (Filed 1/24/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>(http://data.opi.state.mt.us/bills/2005/billhtml/SB0287.htm) |
| NE | Ephedrine (Schedule IV) | NO | LB 481 (Introduced 1/14/05): Makes pseudoephedrine a Schedule V substance and places point of sale restrictions on pseudoephedrine<br>(http://www.unicam.state.ne.us/pdf/INTRO_LB481.pdf)<br>LB 117 (Introduced 1/6/05): Places point of sale restrictions on pseudoephedrine<br>(http://www.unicam.state.ne.us/pdf/INTRO_LB117.pdf) |
| NV | Ephedrine & Pseudoephedrine (Schedule III) | NO | NONE |
| NH | Not Scheduled | NO | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| NJ | Not Scheduled | NO | NONE |
| NM | Not Scheduled | NO | NONE |
| NY | Not Scheduled | NO | AB 215 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://assembly.state.ny.us/leg/?bn=A00215&sh=t)<br>SB 484 (Introduced 1/14/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://public.leginfo.state.ny.us/menugetf.cgi) |
| NC | Not Scheduled | NO | NONE |
| ND | Not Scheduled | YES | HB 1346 (Introduced 1/12/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://www.state.nd.us/lr/assembly/59-2005/bill-index/bi1346.html) |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| OH | Ephedrine (Schedule V) | NO | NONE |
| OK | Ephedrine (Schedule IV) Pseudoephedrine (Schedule V) | YES | NONE |
| OR | Ephedrine & Pseudoephedrine (Schedule II) | YES | Temporary Board of Pharmacy rule places point of sale restrictions on pseudoephedrine (http://www.pharmacy.state.or.us/)<br>SB 313 (Introduced 1/13/05): Places point of sale restrictions on ephedrine & pseudoephedrine (http://www.leg.state.or.us/05reg/measpdf/sb0300.dir/sb0313.intro.pdf) |
| PA | Not Scheduled | NO | NONE |
| RI | Not Scheduled | NO | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| SC | Not Scheduled | NO | NONE |
| SD | Ephedrine (Schedule III) | NO | NONE |
| TN | Not Scheduled | NO | NONE |
| TX | Not Scheduled | NO | SB 107 (Introduced 1/11/05) and SB 112 (Introduced 1/11/05): Place point of sale restrictions on pseudoephedrine (http://www.capitol.state.tx.us/tlo/legislation/bill_status.htm) |
| UT | Not Scheduled | YES | NONE |

© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| VT | Not Scheduled | NO | NONE |
| VA | Not Scheduled | NO | NONE |
| WA | Ephedrine & Pseudoephedrine (Schedule II) | YES | HB 1017 (Introduced 1/10/05)and HB 1018 (Introduced 1/10/05): Places point of sale restrictions on ephedrine & pseudoephedrine<br>SB 5123 (Introduced 1/13/2005): Places point of sale restrictions on ephedrine & pseudoephedrine<br>(http://www.leg.wa.gov/wsladm/billinfo1/bills.cfm) |
| WV | Not Scheduled | NO | NONE |
| WI | Ephedrine (Schedule IV) | NO | NONE |

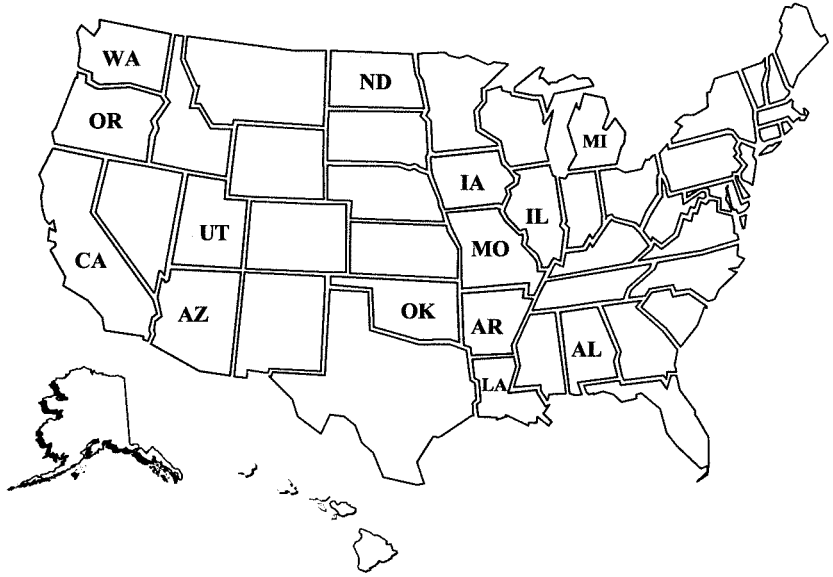
© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

| STATE | CURRENTLY SCHEDULES | CURRENTLY HAS POINT OF SALE RESTRICTIONS | CURRENT BILLS |
|---|---|---|---|
| WY | Not Scheduled | NO | HB 100 (Introduced 1/11/05): Places point of sale restrictions on pseudoephedrine (http://legisweb.state.wy.us/2005/Introduced/HB0100.pdf)<br>HB 249 (Introduced 1/17/05): Places point of sale restrictions on pseudoephedrine (http://legisweb.state.wy.us/2005/Introduced/HB0249.pdf) |



© 2005 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.

**States That Have Quantity Restrictions on the Possession, Purchase, Sale or Transfer of Pseudoephedrine**




© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100. Research current through September 21, 2004.

# RESTRICTIONS ON THE POSSESSION, PURCHASE, SALE OR OTHER TRANSFER OF PSEUDOEPHEDRINE

## OVERVIEW

A decade ago, methamphetamine laboratories were primarily associated with the Western United States. Today, more and more states in the Midwest and eastward are facing the negative consequences of increasing numbers of laboratories surfacing within their borders. Pseudoephedrine, an ingredient in numerous over-the-counter sinus medicines and other medications, has become the primary precursor used to illegally manufacture methamphetamine.

Super labs once dominated the illegal production market, producing bulk quantities of methamphetamine. For their operations, "cookers" would often obtain bulk transfers of precursor chemicals, through theft or purchase. Many states now addressing the methamphetamine problem find that small labs are their primary problem. Smaller labs produce smaller amounts of methamphetamine at any one time. Consequently, operators of these illegal labs often obtain pseudoephedrine through theft or purchase of smaller amounts of over-the-counter products containing pseudoephedrine. The products are broken down chemically and the pseudoephedrine is extracted. The various amounts of pseudoephedrine are then aggregated to create the amount necessary for a particular batch of methamphetamine.

Controlling access to pseudoephedrine to prevent its diversion into illegal manufacturing channels has become a priority for state leaders. At the same time, these decisionmakers recognize that this chemical has legitimate and significant medical usage, and must remain available to legitimate consumers and health care professionals. State officials are therefore striving to achieve a balance in their legislative and policy efforts to limit access to pseudoephedrine.

This compilation of state statutory summaries outlines the quantity restrictions 14 states have legislatively imposed on the possession, purchase, sale or other transfer of pseudoephedrine. These states are: Alabama, Arizona, Arkansas, California, Illinois, Iowa, Louisiana, Michigan, Missouri, North Dakota, Oklahoma, Oregon, Utah and Washington.

The quantity restrictions are often framed in terms of the number of packages or products containing pseudoephedrine, or quantity of pseudoephedrine, which can be sold in a single over-the-counter sale. Generally, a maximum of 2 or 3 packages may be sold in an individual transaction. Several states impose a maximum limit of the amount of

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## ALABAMA

## ALA. CODE § 20-2-190 (2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

No person shall deliver in any single over-the-counter sale more than three (3) packages, or any number of packages, with a combined total of nine (9) grams of product containing pseudoephedrine as the sole active, or in combination with other active ingredients.

**Packaging Restrictions:**

Products in strength of 60 mg. or more per tablet whose sole active ingredient is pseudoephedrine must be sold only in blister packages.

**Restrictions on Display of or Offer for Sale of Product**:

Products whose sole active ingredient is pseudoephedrine must be stored behind a counter or barrier so that it is not accessible by the public, and only accessible by a retail store employee.

**Exemptions from Restrictions**:

The restrictions on quantity, packaging and display do not apply to:

(1) pediatric products labeled pursuant to federal regulation primarily intended for administration to children under 12 years of age according to label instructions.

(2) products the Pharmacy Board, upon application of a manufacturer, exempts because the product is formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine or its salts or precursors.

**Considerations for Reducing or Eliminating Penalties:**

A retailer who is a general owner or operator of an establishment where pseudoephedrine products are available for sale shall not be penalized for a violation of the restrictions if the retailer documents that an employee training program was conducted or approved by the AL Methamphetamine Abuse Task Force.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## ARIZONA

### ARIZ. REV. STAT. ANN. § 13-3404.01 (West 2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

(1) A retailer shall not sell more than 24 grams of ephedrine, pseudoephedrine, (-)-norpseudophedrine or phenylpropanolamine in a single transaction.

(2) A person shall not knowingly sell, transfer or otherwise furnish more than 24 grams of any precursor chemical, including pseudoephedrine, without a properly issued license or permit.

(3) A person shall not sell, transfer or furnish ephedrine, pseuodephedrine, (-)-norpseudoephedrine or phenylpropanolamine in a total amount of more than 24 grams in a single transaction unless the recipient possesses a valid and current, properly issued permit.

(4) A person shall not knowingly possess or purchase more than 24 grams of ephedrine or pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine without a properly issued license or permit.

**Exemptions from Restrictions:**

This Section does not apply to:

(1) the transfer by a licensee or permittee to a reclamation facility for destruction.

(2) the movement from one facility of a licensee or permittee to another facility of the same licensee or permittee without sale.

**Preemption:**

Notwithstanding any other law, a county, city or town shall not enact an ordinance that is more restrictive than the requirements stated in this Section.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**ARKANSAS**

**ARK. CODE ANN. § 5-64-1101 (Michie 2003)**
**ARK. CODE ANN. § 5-64-1103 (Michie 2003)**

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

**§ 5-64-1103**

(1) It is unlawful for a retail distributor or employee of a retail distributor to knowingly sell, transfer or otherwise furnish in a single transaction:

(a) more than three (3) packages of one or more products that the distributor or employee knows to contain ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers; OR

(b) any single package of any product that the distributor or employee knows to contain ephedrine, pseudophedrine or phenylpropanolamine:

(I) which contains more than 96 pills, tablets, gelcaps, capsules or other individual units; OR

(II) more than three (3) grams of ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, or a combination of any of these substances, whichever is smaller; OR

(c ) any product containing ephedrine, pseudophedrine, or phenylpropanolamine, unless the product complies with the packaging restrictions of this Section; OR

(d) any product containing ephedrine, pseudophedrine or phenylpropanolamine to any person under the age of 18, unless the person is purchasing a pediatric product intended for a child.

(2) It is unlawful for any person, other than a person or entity described in § 5-64-1101 to knowingly purchase, acquire or otherwise receive in a single transaction:

(a) more than three (3) packages of one or more products that the person knows to contain ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers; OR

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

pseudoephedrine which may be contained in the total number of packages sold. Some states limit of the amount of grams of pseudoephedrine which may be sold or possessed, with the maximum amount often listed as nine (9) or twelve (12) grams.

The state summaries will also discuss requirements for how products containing pseudoephedrine must be packaged, displayed or offered for sale. Packaging restrictions often require products to be in blister packs, or where blister packs are infeasible, in unit dose packets or pouches. Individual packages often cannot contain more than three (3) grams of pseudoephedrine.

Display restrictions often require products containing pseudoephedrine to be placed behind a counter or other barrier inaccessible to the public, or within the line of sight of an employee. Some states discuss other options for offering such products for sale, including using antitheft devices, locked display cases or video camera surveillance.

Exemptions to requirements on quantities sold or possessed, and on packaging or display restrictions will be outlined for each state in which the exemptions apply. Two of the common exemptions are for specified forms of pediatric products, and for products deemed to be formulated in a way to effectively prevent the conversion of the active ingredient into methamphetamine.

Lastly, each summary will indicate whether, and to what extent, the state-imposed restrictions preempt local ordinances or regulations.

**Exemptions from Restrictions:**

Section § 5-64-1103 does not apply to:

(1) pediatric products primarily intended for administration to children under 12 years of age, according to label instructions, either:

(A) in solid dosage form whose individual dosage units, according to label instructions, does not exceed 15 milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine; OR

(B) in liquid form whose recommended dosage, according to label instructions, does not exceed 15 mg. of ephedrine, pseudoephedrine, or phenylpropanolamine per five milliliters of liquid product;

(2) pediatric liquid products primarily intended for administration to children under two years of age for which the recommended dosage does not exceed two (2) milliliters and the total package content does not exceed one fluid ounce; OR

(3) products the Pharmacy Board , upon application, exempts because the product has been formulated in such a way to effectively prevent the conversion of the active ingredient into methamphetamine or its salts or precursors.

Section §5-64-1101 does not apply to:

(1) any pharmacist or other authorized person who sells or furnishes ephedrine, pseudoephedrine, or phenylpropanolamine, or their salts, optical isomers and salts of optical isomers, upon the prescription of a physician, dentist, podiatrist, or veterinarian; OR

(2) possession, without a prescription, pursuant to federal law, provided that the person possesses a proper sales and use tax permit; OR

(3) any physician, dentist, podiatrist or veterinarian who administers or furnishes ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers to his or her patients; OR

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## CALIFORNIA

## CAL. HEALTH & SAFETY CODE § 11100 (West 2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

(1) Notwithstanding any other law, it is unlawful for any retail distributor:

(a) to sell in a single transaction more than three (3) packages of a product he or she knows to contain ephedrine, pseudoephedrine, norpseudoephedrine or phenylpropanolamine; OR

(b) to knowingly sell more than nine (9) grams of ephedrine, pseudoephedrine, norpseudoephedrine or phenylpropanolamine, other than pediatric liquids as defined in this Section.

(2) It is unlawful for any manufacturer, wholesaler, retailer or other person to sell, transfer, or otherwise furnish a substance identified in this Section, including pseudoephedrine, to a person under 18 years of age.

(3) It is unlawful for any person under 18 years of age to possess a substance identified in this Section, including pseudoephedrine.

Definition: A pediatric liquid means a nonencapsulated liquid whose unit measure according to product labeling is stated in milligrams, ounces, or other similar measure. In no instance shall the dosage units exceed 15 milligrams of phenylpropanolamine or pseudoephedrine per five (5) milliliters of liquid product, except for liquid products primarily intended for administration to children under two (2) years of age for which the recommended dosage unit does not exceed two (2) milliliters and the total package content does not exceed one fluid ounce.

**Exemptions to Restrictions**:

This Section does not apply to:

(1) any pharmacist or other authorized person who sells or furnishes a substance upon the prescription of a physician, dentist, podiatrist or veterinarian.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**Preemption:**

The quantity, packaging and display restrictions preempt all local ordinances or regulations governing the possession by individuals or a sale by a retail distributor of over-the-counter products containing pseudoephedrine.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

# ILLINOIS

## 720 ILL. COMP. STAT. ANN. 647/1 TO 647/60 (West 2004) (Effective January 1, 2005 – Methamphetamine Manufacturing Chemical Retail Sale Control Act)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

A retail distributor may not distribute more than two (2) targeted packages in a single retail transaction.

Definitions:

A targeted package is a package containing any amount of a targeted methamphetamine manufacturing chemical.

A targeted methamphetamine manufacturing chemical is any medication in the form of tablet, capsule, caplet or similar product sold over-the-counter, without a prescription, and that contains:

(A) more than 15 milligrams of ephedrine or its salts, optical isomers or salts of optical isomers; OR

(B) more than 15 milligrams of pseudoephedrine or its salts, optical isomers or salts of optical isomers.

**Packaging Restrictions:**

(1) Any targeted methamphetamine manufacturing chemical displayed or distributed by any retail distributor in the state shall be packaged:

(a) in blister packets, with each blister containing no more than two (2) dosage units: OR

(b) in unit dose packets or pouches when the use of blister packs is technically infeasible.

(2) Any targeted package displayed or distributed by any retail distributor in the state shall contain no more than three (3) grams of ephedrine or its salts, optical isomers, or salts of optical isomers, or pseudoephedrine or its salts, optical isomers or salts of optical isomers.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(b) any single package of any product that the person knows to contain ephedrine, pseudophedrine or phenylpropanolamine:

(I) which contains more than 96 pills, tablets, gelcaps, capsules or other individual units; OR

(II) more than three (3) grams of ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, or a combination of any of these substances, whichever is smaller.

**§ 5-64-1101**

(1) It is unlawful for any person to possess more than five (5) grams of ephedrine or nine (9) grams of pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers, alone or in mixture, unless the person qualifies for an exemption as defined in this Section.

(2) Possession of more than five (5) grams of ephedrine or more than nine (9) grams of pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers shall constitute prima facie evidence of intent to manufacture methamphetamine or another controlled substance, unless the person qualifies for an exemption as defined in this Section.

**Packaging Restrictions:**

**§ 5-64-1103**

Products containing ephedrine, pseudoephedrine or phenylpropanolamine must be sold:

(1) in package sizes of not more than three (3) grams of ephedrine, pseudophedrine or phenylpropanolamine base; AND

(2) be packaged in blister packs, each blister containing not more than two (2) dosage; OR

(3) where blister packs is technically infeasible, be packaged in unit dose packets or pouches; OR

(4) in the case of liquids, in package sizes of not more than three (3) grams of ephedrine, pseudophedrine, or phenylpropanolamine base.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(II) Employ a reliable antitheft device that uses special package tags and detection alarms designed to prevent the theft of the packages.

(III) Use restricted access shelving so that only one package can be removed from the shelf at a time and there is a delay of 15 seconds or more between the time one such package is removed and the time the next such package can be removed.

(IV) Keep the packages under constant video surveillance in accordance with the the following requirements:

(A) The video camera is positioned so that person examining or removing the packages are visible.

(B) The video camera must, at a minimum, record a one-second image every ten (10) seconds.

(C) The images must be preserved for a minimum of 72 hours.

(D) The images must be available to law enforcement immediately upon request, AND

(E) The retail distributor must post a sign in a prominent manner stating that the area is under constant video surveillance.

Definitions:

(1) A single active ingredient targeted package is a package containing any amount of single active ingredient targeted methamphetamine manufacturing chemical.

(2) A single active ingredient targeted methamphetamine manufacturing chemical is a targeted methamphetamine manufacturing chemical whose sole active ingredient is ephedrine or its salts, optical isomers or salts of optical isomers; or pseudoephedrine or its salts, optical isomers or salts of optical isomers.

(3) A multiple active ingredient targeted package is a package containing any amount of multiple active ingredient targeted methamphetamine manufacturing chemical.

(4) A multiple active ingredient targeted methamphetamine manufacturing chemical means a targeted methamphetamine manufacturing chemical that contains at least one active ingredient other than ephedrine or its salts, optical isomers, or salts of optical isomers; or pseudoephedrine or its salts, optical isomers, or salts of optical isomers.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(4)(A) any manufacturer, wholesaler, or distributor licensed by the Pharmacy Board who meets one of the requirements listed in (B) and sells, transfers, or otherwise furnishes ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers, and salts of optical isomers to a licensed pharmacy, physician, dentist, podiatrist, veterinarian, or any person who possesses a proper sales and use tax permit.

(B)(i) The manufacturer, wholesaler, or distributor must hold or store the substances in facilities that satisfy proper packaging requirements.

(ii) The manufacturer, wholesaler, or distributor must sell, transfer, or otherwise furnish only to healthcare professionals identified in (1) and (3).

**Considerations for Reducing or Eliminating Penalties**:

The prosecuting attorney may waive any civil penalty if the retail distributor or employee of the retail distributor establishes that he or she acted in good faith to prevent violations, and the violations occurred despite the exercise of due diligence.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## IOWA

## IOWA CODE ANN. § 126.23A (West 2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

A retailer shall not sell and a person shall not purchase in a single transaction more than two (2) packages containing pseudoephedrine as the products' sole active ingredient.

**Restrictions on Display of or Offer for Sale of Product**:

A product containing pseudoephedrine as the product's sole active ingredient shall be:

1. behind a counter where the public is not permitted; OR

2. within 20 feet of a counter which allows an attendant to view the product in an unobstructed manner.

**Exemptions from Restrictions:**

(1) This Section does not apply to any package of a product containing pseudoephedrine as the product's sole active ingredient which is:

(a) in liquid form.

(b) primarily intended for administration to children under 12 years of age, whether the product is in liquid or solid form.

(c) exempted by the Board of Pharmacy Examiners, with the concurrence of the Department of Public Safety, and upon application of a manufacturer, because the product is formulated to effectively prevent conversion of the active ingredient into methamphetamine or its salts or precursors.

(2) A retailer may display or offer for sale without restriction if the product is displayed using any type of antitheft device system, including but not limited to, an electronic antitheft device system that uses a product tag and detection alarm which prevents theft.

**Preemption:**

A county or municipality shall not set requirements or establish a penalty which is higher or more stringent than the requirements or penalties listed in the state law.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(2) any physician, dentist, podiatrist, or veterinarian who administers or furnishes a substance to his or her patients.

(3) any manufacturer or wholesaler licensed by the Pharmacy Board that sells, transfers, or otherwise furnishes a substance to a licensed pharmacy, physician, dentist, podiatrist, veterinarian, or retail distributor, provided that the manufacturer or wholesaler submits records of any suspicious sales or transfers as determined by the Department of Justice.

(4) any analytical research facility that is registered with the federal Drug Enforcement Administration (DEA).

(5) any sale, transfer, furnishing or receipt of any over-the-counter product lawfully sold, transferred or furnished without a prescription pursuant to federal law which:

a. contains ephedrine, pseudoephedrine, norpseudoephedrine or phenylpropanolamine; AND

b. is in pediatric liquid form.

(6) any sale, transfer, furnishing or receipt of any over-the-counter product lawfully sold, transferred or furnished without a prescription pursuant to federal law which:

a. is in solid or liquid dosage form, except as provided in (5); AND

b. contains ephedrine, pseudoephedrine, norpsedoephedrine, or phenylpropanolamine; AND

c. involves an individual transaction of three (3) or less packages or nine (9) grams or less of a substance listed in (6)(b).

(7) any transfer of a substance identified in this Section, including pseudoephedrine, for purposes of lawful disposal as waste.

**Preemption:**

This section preempts all local ordinances or regulations governing the sale by a retail distributor of over-the-counter products containing ephedrine, pseudoephedrine, norpseudoephedrine, or phenylpopanolamine.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## LOUISIANA

### LA. REV. STAT. ANN. § 40:962.1.1 (West 2004)
### 2004 La. Sess. Law Serv. Act 656 (West)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

(1) It is unlawful for any person to possess 12 grams or more of ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers or salts of optical isomers.

(2) It is unlawful for any person to possess ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers or salts of optical isomers in powder form unless:

(a) the weight of the ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers or salts of optical isomers is less than 12 grams; AND

(b) the powder is in the manufacturer's original packaging; AND

(c) the powder may be lawfully sold over-the-counter without a prescription pursuant to federal law.

**Exemptions from Restrictions:**

(1) This Section does not apply to:

(a) any person possessing a valid prescription for ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers.

(b) any licensed manufacturer, wholesaler or distributor who sells, transfers or otherwise furnishes ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers to any licensed practitioner operating within the course and scope of that profession.

(c) any licensed pharmacist or other authorized person who sells or furnishes ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers in the course of their professional practice, pursuant to the prescription of any licensed practitioner.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**Restrictions on Display of or Offer for Sale of Product:**

(1) A retail distributor may not permit the purchase of a targeted package by means of a self-service checkout (checkout) unless the checkout is programmed to satisfy all of the following conditions for each retail transaction:

(a) The checkout allows the customer to purchase a single targeted package without special prompts or actions.

(b) The checkout requires the customer to seek the assistance of a sales employee to purchase a second targeted package.

(c) Neither the checkout nor the employee shall allow the customer to purchase a third targeted package.

(2) All single active ingredient targeted packages shall be displayed:

(a) behind a store counter, in an area not accessible to customers; OR

(b) in a locked case so that a customer wanting access to the package must ask a store employee for assistance.

(3) Multiple active ingredient targeted packages (package(s)) must be displayed and sold in at least one of the following four (4) ways:

(a) The packages may be located behind a store counter, in an area not accessible to customers; OR

(b) The packages may be placed in a locked case so that a customer wanting access to the packages must ask a store employee for assistance; OR

(c) The retail distributor may require the customer making a purchase to produce a state-issued photo identification featuring a photograph that reasonably resembles the customer AND record the customer's name, issuing state, and official identification number into a log; OR

(d) The retail distributor must adopt at least two (2) of the following options:

(I) Locate the packages within 30 feet and the direct line of sight of a cash register or store counter staffed by one or more store employees.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## MICHIGAN

## MICH. COMP. LAWS ANN. § 333.17766c (West 2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

A person shall not possess more than 12 grams of ephedrine or pseudoephedrine alone or in a mixture.

**Exemptions from Restrictions:**

This Section does not apply to:

(1) a person who possesses ephedrine or pseudoephedrine pursuant to a license issued by the state or the United States to manufacture, deliver, dispense, possess with intent to manufacture or deliver, or possess a controlled substance, prescription drug or other drug.

(2) an individual who possesses ephedrine or pseudoephedrine pursuant to a prescription.

(3) a person who possesses ephedrine or pseudophedrine for retail sale pursuant to a licensed issued under the general sales tax act.

(4) a person who possess ephedrine or pseudoephedrine in the course of his or her business of selling or transporting ephedrine or pseudoephedrine to a person in (1) or (3).

(5) a person who, in the course of his or her business, stores ephedrine or pseudoephedrine for sale or distribution to a person in (1), (3) or (4).

(6) a product that the Pharmacy Board, upon application of a manufacturer, exempts because the product has been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine.

(7) any pediatric product primarily intended for administration to children under 12 years of age, according to label instructions.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**Exemptions from Restrictions:**

(1) The definition of a targeted methamphetamine manufacturing chemical excludes any medication in the form of a liquid, liquid cap, gelcap or other similar substance, or any medication dispensed by a licensed pharmacist pursuant to a valid prescription.

(2) The Act does not apply to the sale of a targeted methamphetamine manufacturing chemical that was produced in a manner, as formally certified by DEA, that prevents its use for the manufacture of methamphetamine.

**Considerations for Reducing or Eliminating Penalties:**

(1) Any retail distributor that tries to comply with the two package limitation by installing automated cash register prompts informing sales employees when the two package limit has been exceeded is subject to a lesser fine for the violation.

(2) The owner and operator of a retail distributor are not liable for any violation of the two package limitation only if the owner and operator:

(a) strictly complied with packaging restrictions, conditions of self-service checkout stations, display restrictions and requirements for training of employees;

(b) made a good faith effort to ensure compliance with the two package limitation, and the prohibition against distributing packages with knowledge that, or with reckless disregard that the packages would likely be used to manufacture methamphetamine;

(c) made a good faith effort to comply with requirements to obtain and retain employee certification; AND

(d) had no advance knowledge of the violation(s) and did not act in reckless disregard of the likelihood of such violation(s).

**Preemption:**

Except for a regulation by a home rule unit that took effect on or before May 1, 2004, a county or municipality, including a home rule unit, may regulate the sale of targeted methamphetamine manufacturing chemicals and targeted packages in a manner that is not more or less restrictive than the regulation by the State under this Act.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## MISSOURI

## MO. ANN. STAT. § 195.417 (West 2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

No person shall deliver in any single over-the-counter sale more than:

(1) Two (2) packages, or any number of packages that contain a combined total of no more than six (6) grams of any drug containing a sole active ingredient of ephedrine, pseudoephedrine, phenylpropanolamine or any of their salts, optical isomers or salts of optical isomers; OR

(2) Three (3) packages of any combination drug containing, as one of its active ingredients, ephedrine, pseudoephedrine, phenylpropanolamine or any of their salts, optical isomers or salts of optical isomers, or any number of packages of said combination drug that contain a combined total of no more than nine (9) grams of ephedrine, pseudoephedrine, phenylpropanolamine or any of their salts, optical isomers, or salts of optical isomers.

**Restrictions on Display of or Offer for Sale of Product:**

Packages of any drug having a sole active ingredient of ephedrine, pseudoephedrine, phenylpropanolamine or any of their salts or optical isomers, shall be displayed and offered for sale only:

(1) behind a checkout counter where the public is not permitted; OR

(2) within ten (10) feet and an unobstructed view of an attended checkout counter.

**Exemptions from Restrictions:**

(1) The display restrictions shall not apply to any retailer using an electronic antitheft system that uses a product tag and detection alarm which specifically prevents the theft of such drugs from the place of business where such drugs are sold.

(2) This Section does not apply to:

(a) any product labeled pursuant to federal regulation for use only in children under 12 years of age; OR

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(d) any licensed practitioner who administers or furnishes ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers in the course of their professional practice.

(e) any person in possession of ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of optical isomers in his or her residence under circumstances that are consistent with typical medicinal or household use.

Such use may be indicated by storage location, purchase date, expiration date, possession of the products in a variety of strengths, brands, types or purposes and the health conditions of persons in the residence.

(f) any manufacturer, wholesaler, distributor or retail business which sells, transfers or otherwise furnishes products to customers for medicinal purposes, which products contain ephedrine, pseudoephedrine or phenylpropanolamine or their salts, optical isomers and salts of isomers, while acting within the scope and course of that business.

(2) This Section does not apply to any pediatric products primarily intended for administration, according to label instructions, to children under 12 years of age, provided that:

(a) for any solid dosage form, the individual dosage unit, according to label instructions, does not exceed 15 milligrams of ephedrine, pseudoephedrine or phenylpropanolamine.

(b) for any liquid dosage form:

(I) the recommended dosage units, according to label instructions, does not exceed 15 milligrams of ephedrine, pseudoephedrine or phenylpropanolamine per five (5) milliliters of the liquid product.

(II) which is intended for administration to children under two (2) years of age:

(A) the recommended dosage does not exceed two (2) milliliters; AND

(B) the total package content is not more than one fluid ounce.

(3) The Department of Health and Hospitals is authorized to exempt products that are formulated to effectively prevent conversion of the active ingredient into amphetamine or methamphetamine.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## NORTH DAKOTA

**N.D. CENT. CODE § 19-03.1-01 (2003)**
**N.D. CENT. CODE § 19-03.4-07 (2003)**
**N.D. CENT. CODE § 19-03.4-08 (2003)**

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

**§ 19-03.4-08**

A person may not deliver in a single over-the-counter sale:

(1) more than two (2) packages of a methamphetamine precursor drug or a combination of methamphetamine precursor drugs; OR .

(2) a methamphetamine precursor drug to a person less than 18 years of age.

**§ 19-03.4-07**

Possession of more than 24 grams of a methamphetamine precursor drug or combination of methamphetamine precursor drugs calculated in terms of ephedrine HCI or pseudoephedrine HCI is prima facie evidence of intent to violate the controlled substances act.

Definition:

A methamphetamine precursor drug is a drug or product containing ephedrine, pseudoephedrine or any of their salts, optical isomers or salts of optical isomers.

**Packaging Restrictions:**

**§ 19-03.4-08**

A retail sale of nonliquid methamphetamine precursor drugs is limited to:

(1) sales in packages containing not more than three (3) grams of one or more methamphetamine precursor drugs, calculated in terms of ephedrine HCI and pseudoephedrine HCI; AND

(2) sales in blister packs, each blister containing not more than two (2) dosage units, OR

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(b) any product the state department of health and senior services, upon application of a manufacturer, exempts because the product has been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine, or its salts or precursors; OR

(c) to the sale of any animal feed products containing ephedrine; OR

(d) any naturally occurring or herbal ephedra or extract of ephedra.

**Preemption:**

This Section supersedes any municipal ordinances or regulations passed on or after December 23, 2002, to the extent that such ordinances or regulations are more restrictive than the provisions of this Section.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## OKLAHOMA

**OKLA. STAT. ANN. tit. 63, § 2-212 (West 2004)**
**OKLA. STAT. ANN. tit. 63, § 2-332 (West 2004)**

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

**tit. 63, § 2-212**

No person shall purchase, receive, or otherwise acquire more than nine (9) grams of any product, mixture, or preparation containing any detectable quantity of pseudoephedrine, its salts or optical isomers, or salts of optical isomers within any 30 day period.

**tit. 63, § 2-332**

Possession of a drug product containing more than nine (9) grams of ephedrine, pseudoephedrine, or phenylpropanolamine, or their salts, isomers or salts of isomers shall constitute a rebuttable presumption of the intent to use the product as a precursor to methamphetamine or another controlled substance.

**Restrictions on the Display of or Offer for Sale of Product:**

**tit. 63, § 2-212**

(1) Schedule V controlled substances include any compound, mixture, or preparation containing any detectable quantity of pseudoephedrine, its salts or optical isomers, or salts of optical isomers.

(2) If any compound, mixture, or preparation is dispensed, sold, or distributed in a pharmacy:

(a) it shall be dispensed, sold, or distributed only by, or under the supervision of, a licensed pharmacist or a registered pharmacy technician, AND

(b) any person purchasing, receiving, or otherwise acquiring any compound, mixture, or preparation shall:

(I) produce a photo identification showing the date of birth of the person; AND

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(3) sales in unit dose packets or pouches when the use of blister packs is technically infeasible.

**Exemptions from Restrictions:**

(1) Section 19-03.4-08 does not apply to:

(a) pediatric products labeled pursuant to federal regulations which are primarily intended for administration to children under 12 years of age, according to label instructions; OR

(b) a product the Pharmacy Board, upon application of a manufacturer, exempts because the product has been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine or its salts or precursors.

(2) Section 19-03.4-07 does not apply to a practitioner as defined in § 19-03.1-01 or to a product possessed in the course of a legitimate and lawful business.

**Considerations for Reducing or Eliminating Penalties:**

An owner, operator or manager of the retail outlet or a supervisor of the employee or agent committing a violation of this Section is not subject to penalties if the person:

(1) did not have prior knowledge of, participate in or direct the employee or agent to commit the violation; AND

(2) documents that the employee or agent, at the time of initial employment and each calendar year thereafter, participated in a training program approved by the attorney general providing the employee or agent with information regarding the state and federal regulations governing the sale, possession, and packaging of such drugs.

**Preemption:**

A political subdivision, including home rule city or county, may not enact any ordinance relating to the sale by a retail distributor of over-the-counter products containing ephedrine, pseudoephedrine, or phenylpropanolamine. Any existing ordinance is void.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**OREGON**

**OR. REV. STAT. § 475.973 (2003)**

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

(1) It is unlawful to sell or otherwise transfer more than nine (9) grams of ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, or a combination of any of these substances, to a person other than a veterinarian, physician, pharmacist, retail distributor, wholesaler, manufacturer, warehouseman or common carrier or an agent of any of these persons in the regular course of lawful business activities.

(2) It is unlawful to knowingly possess more than nine (9) grams of ephedrine, pseudoephedrine or phenylpropanolamine, the salts, isomers or salts of isomers of ephedrine, pseudoephedrine or phenylpropanolamine or a combination of any of these substances.

**Exemptions from Restrictions:**

(1) The restrictions on sale or transfer do not apply to:

(a) pediatric products primarily intended for administration, according to label instructions, to children under 12 years of age either:

(I) in solid dosage form when individual dosage units do not exceed 15 milligrams of ephedrine, pseudoephedrine or phenylpropanolamine; OR

(II) in liquid form when recommended dosage units, according to label instructions, do not exceed 15 milligrams of ephedrine, pseudoephedrine or phenylpropanolamine per five (5) milliliters of liquid product.

(b) pediatric products primarily intended for administration to children under two (2) years of age for whom the recommended dosage does not exceed two (2) milliliters and that have a total package content of not more than one fluid ounce.

(2) The restrictions on possession do not apply to:

(a) a veterinarian, physician, pharmacist, retail distributor, wholesaler, manufacturer, warehouseman or common carrier or an agent of any of these persons if the possession is in the regular course of lawful business activities.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(II) sign a written log, receipt, or other program or mechanism approved by the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, showing the date of the transaction, name of the person, and the amount of the compound, mixture, or preparation.

**Exemptions from Restrictions:**

**tit. 63, §2-212**

(1) The quantity restriction in tit.63, § 2-212 does not apply to any quantity of a product, mixture or preparation dispensed pursuant to a valid prescription.

(2) Schedule V as it applies to compounds, mixtures or preparations containing any detectable quantity of pseudeophedrine, its salts or optical isomers, or salts of optical isomers, shall not apply to any compounds, mixtures, or preparations which are in liquid, liquid capsule, or gel capsule form if pseudoephedrine is not the only active ingredient.

(3) The Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control (Director) may exempt other products from Schedule V if he finds the products are not used in the illegal manufacture of methamphetamine or other controlled dangerous substances.

A manufacturer of a drug product may apply for removal of the product from Schedule V if the product is determined by the Director to have been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine.

**tit. 63, §2-332**

The rebuttable presumption in this Section does not apply to:

(1) a retail distributor of drug products or wholesaler;

(2) a wholesale drug distributor, or its agents, licensed by the Pharmacy Board;

(3) a manufacturer of drug products, or its agents, licensed by the Pharmacy Board;

(4) a pharmacist licensed by the Pharmacy Board; AND

(5) a licensed healthcare professional possessing the drug products in the course of carrying out his or her profession.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## UTAH

## UTAH CODE ANN. § 58-37C-20 (2004)

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

It is unlawful for any person to possess more than 12 grams of ephedrine or pseudoephedrine, their salts, isomers or salts of isomers, or a combination of any of these substances, if the person:

(1) is not licensed to engage in regulated transactions; AND

(2) is not excepted from licensure.

If the possession occurs under circumstances not constituting precursor act violations, or other specified violations, the person is guilty of a Class A misdemeanor.

**Exemptions from Restrictions:**

(1) This Section does not apply to dietary supplements, herbs or other natural products, including concentrates or extracts which:

(a) are not otherwise prohibited by law; AND

(b) may contain naturally occurring ephedrine, ephedrine alkaloids or pseudoephedrine or their salts, isomers or salts of isomers, or a combination of these substances, that:

(I) are contained in a matrix of organic material; and

(II) do not exceed 15% of the total weight of the natural product.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(b) a person in possession of less than 24 grams of ephedrine, pseudoephedrine or phenylpropanolamine or their salts, isomers or salts of isomers, in the home or residence of the person under circumstances that are consistent with typical medical or household use.

Such use is indicated by factors that include, but are not limited to, storage location, purchase date, possession of the products in a variety of strengths, brands, types or purposes and the expiration date.

This exception does not apply if the substances, in excess of nine (9) grams, were all purchased within a period of seven (7) consecutive days.

(3) This Section does not apply to products that the Pharmacy Board, upon application of a manufacturer, exempts because the product is formulated to effectively prevent conversion of the active ingredient into methamphetamine or its salts or precursors.

Upon notification from the State Police that there is probable cause to believe a product exempted does not effectively prevent conversion of the active ingredient into methamphetamine or its salts or precursors, the Pharmacy Board may issue an emergency rule revoking the exemption for the product pending a full hearing.

(4) This Section does not apply to dietary supplement, herbs or natural products, including concentrates or extracts, that are not otherwise prohibited by law and that contain naturally occurring ephedrine alkaloids in a matrix of organic material such that the substances do not exceed 15 percent of the total weight of the dietary supplement, herb or natural product.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

## WASHINGTON

**WASH. REV. CODE ANN. § 18.64.044 (West 2004)**
**WASH. REV. CODE ANN. § 18.64.046 (West 2004)**
**WASH. REV. CODE ANN. § 18.64.047 (West 2004)**
**WASH. REV. CODE ANN. § 69.43.110 (West 2004)**
**WASH. REV. CODE ANN. § 69.43.120 (West 2004)**
**WASH. REV. CODE ANN. § 69.43.130 (West 2004)**

**Quantity Restrictions on the Possession, Purchase, Sale or Other Transfer of Pseudoephedrine:**

**§ 69.43.110**

(1) It is unlawful for a pharmacy licensed by, or a shopkeeper or itinerant vendor registered with, the department of health, or an employee thereof, or a practitioner, knowingly to sell, transfer, or to otherwise furnish in a single transaction:

(a) more than three (3) packages of one or more products that he or she knows to contain ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers, or salts of isomers; OR

(b) a single package of any product he or she knows to contain more than three (3) grams of ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, or a combination of any of these substances.

(2) It is unlawful for a person who is not a manufacturer, wholesaler, pharmacy, practitioner, shopkeeper or itinerant vendor licensed by or registered with the department of health to purchase or acquire, in any 24 hour period, more than the quantities identified in (1).

**§ 69.43.120**

It is unlawful for any person to possess more than 15 grams of ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, or a combination of any of those substances.

**§§ 18.64.044 & 18.64.047**

A shopkeeper or itinerant vendor who has purchased ephedrine, pseudoephedrine or phenylpropanolamine or their salts, isomers or salts of isomers, in a suspicious transaction is subject to the following requirements:

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(1) The shopkeeper or itinerant vendor may not sell any quantity of ephedrine, pseudoephedrine or phenylpropanolamine, or their salts, isomers, or salts of isomers, if the total monthly sales of these products exceed ten (10) percent of the shopkeeper's or itinerant vendor's total prior monthly sales of nonprescription drugs in March through October. Monthly sales means total dollars paid by buyers.

(2) In November through February, the shopkeeper or itinerant vendor may not sell any quantity of ephedrine, pseudoephedrine, or phenylpropanolamine or their salts, isomers or salts of isomers, if the total monthly sales of the products exceed 20% of the shopkeeper's or itinerant vendor's total prior monthly sales of nonprescription drugs.

(3) The shopkeeper or itinerant vendor shall also maintain inventory records pursuant to requirements of this Section.

Definition:

A suspicious transaction is a sale or transfer in which:

(1) The circumstances would lead a reasonable person to believe that the substance is likely to be used for the purpose of unlawfully manufacturing a controlled substance, based on such factors as: the amount involved, the method of payment, the method of delivery, and any past dealings with any participant in the transaction; OR

(2) The transaction involves payment for specified substances in cash or money orders in a total amount of more than $200.

**§ 18.64.046**

(a) No wholesaler may sell any quantity of drug products containing ephedrine, pseudoephedrine, phenylpropanolamine, or their salts, isomers or salts of isomers if the total monthly sales of these products to persons within the state exceed five (5) percent of the wholesaler's total prior monthly sales of nonprescription drugs to persons within the state in March through October. Monthly sales means total dollars paid by buyers.

(b) In November through February, no wholesaler may sell any quantity of drug products containing ephedrine, pseudoephedrine, or phenylpropanolamine, or their salts, isomers, or salts of isomers if the total monthly sales of these products to persons within the state exceed ten (10) percent of the wholesaler's total prior monthly sales of nonprescription drugs to persons within the state.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

**Exemptions from Restrictions:**

**§ 69.43.120**

This Section does not apply to:

(1) a pharmacist or other authorized person who sells or furnishes ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, upon prescription of a practitioner; OR

(2) a practitioner who administers or furnishes ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers, or salts of isomers to his or her patients; OR

(3) a pharmacy, manufacturer, or wholesaler licensed by, or shopkeeper or itinerant vendor registered with, the department of health; OR

(4) a person in the course of his or her business of selling, transporting or storing ephedrine, pseudoephedrine or phenylpropanolamine, their salts, isomers or salts of isomers, for a person in (1), (2), or (3); OR

(5) a person in possession of more than 15 grams of ephedrine, pseudoephedrine, phenylpropanolamine, their salts, isomers, or salts of isomers in their home or residence under circumstances consistent with typical medical or household use.

Such use is indicated by, but not limited to, storage location and possession of products in a variety of strengths, brands, types, purposes and expiration dates.

**§ 69.43.130**

Sections 69.43.110 and 69.43.120 do not apply to:

(1) pediatric products:

(a) primarily intended for administration to children under 12 years of age, according to label instructions, either:

(I) in solid dosage form whose individual dosage units do not exceed 15 milligrams of ephedrine, pseudoephedrine or phenylpropanolamine; OR

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

(II) in liquid form whose recommended dosage, according to label instructions, does not exceed 15 milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine per five (5) milliliters of liquid product; OR

(b) primarily intended for administration to children under two (2) years of age for which the recommended dosage does not exceed two (2) milliliters and the total package content does not exceed one fluid ounce.

(2) products that the Pharmacy Board, upon application, exempts because:

(a) the product has been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine, or its salts or precursors; OR

(b) the product meets the federal definition of an ordinary over-the-counter pseudoephedrine product as defined in 21 U.S.C. §802; AND

(c) the product is a salt, isomer, or salts of isomers of pseudoephedrine and, as packaged, has a total weight of more than three (3) grams but the net weight of the pseudoephedrine base is equal to or less than three (3) grams; AND

(d) the Pharmacy Board determines that the value to people of having the product, as packaged, available for sale to consumers, outweighs the danger, and the product, as packaged, has not been used in the illegal manufacture of methamphetamine.

**§ 18.64.046**

The Pharmacy Board may exempt a wholesaler from the quantity restrictions of this Section if it finds that the wholesaler distributes nonprescription drugs only through transactions between divisions, subsidiaries, or related companies when the wholesaler and the retailer are related by common ownership, and that neither wholesaler nor the retailer has a history of suspicious transactions in precursor drugs.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria VA 22314 (703) 836-6100. Research current through September 21, 2004.

# STATE ENVIRONMENTAL CLEANUP AND REMEDIATION OVERVIEW

As the methamphetamine epidemic continues to sweep across the nation, new statutes, regulations, local ordinances, and guidelines relating to the cleanup and remediation of methamphetamine laboratories are emerging. State and local governments are working to address different aspects of the indoor and outdoor environmental issues associated with clandestine laboratories. A few states have been dealing with the environmental contamination of these drug laboratory sites head-on for many years and have significant statutory and regulatory provisions in place. Others on the federal, state, and local level have more recently begun to address this issue.

Please note that our research is ongoing in this arena and in no way do we want to represent that we are experts on your state and local laws. In particular, we understand that we may not be currently familiar with all of the different categories of laws that states may be using for cleanup and remediation because of the wide breadth of this issue. We continue to collect numerous cleanup ordinances from local governments that cannot currently be obtained through our legal research database.

Additionally, please note that a number of states have put together guidelines or guidance documents for the cleanup and remediation of methamphetamine laboratories. We have defined certain documents as guidelines based on the content provided. Documents we are considering guidelines are those that contain detailed scientific sampling information and remediation standards for methamphetamine. Guidelines do not have the force of law by themselves but in some instances, for example, local governments have passed ordinances requiring cleanup contractors to abide by the procedures and cleanup standards that the guidelines establish. Some of the more

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

comprehensive guidelines include information on chemical toxicity, laboratory analytical methods, asbestos guidelines, and field and sampling guidelines. Those documents that may have the term "guideline" in the title but we have considered them as "guidance documents" are those that tend to be less detailed in nature and do not address a remediation standard for methamphetamine.

Based upon a review of existing state statutes specifically relating to the cleanup and remediation of clandestine laboratories, the application of the cleanup and remediation provisions varies from state to state and is determined by the type of substance being illegally manufactured. Some states only address the manufacture of methamphetamine. Other state statutes apply to the manufacture of controlled substances generally, as they are defined in the state code, or more specifically to "schedule I or II controlled substances." In addition to the above listed, some states also include the manufacturing of ecstasy and LSD. Thus, it appears that some states are more focused particularly on the illegal manufacture of methamphetamine whereas other states have taken a broader approach in their statutory language.

Several state cleanup laws and regulations address the use of a state-approved environmental cleanup contractor and/or a certified industrial or environmental hygienist. Only three states, however, have tackled by statute or regulation the contractor and employee training and certification in detail. In Washington, Oregon, and Arizona, not only does the contractor need to be certified, but the employees and supervisors must all go through a specific training and certification process. According to our contacts within these states, stricter enforcement is needed with respect to the monitoring of contractors and ensuring that they are using certified employees and proper remediation and

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

sampling procedures. Part of the process for monitoring the contractors is the requirement of some type of work plan to be submitted to the overseeing agency. A few states currently require by statute or regulation a work plan to be prepared by the contractor. A work plan may include photographs and/or drawings and a written description of the contaminated property, procedures for the decontamination process, a description of the personal protective equipment that will be used, health and safety procedures, and a list of post-decontamination testing that will be completed. In addition to above discussed training and certification requirements, Washington, in particular, also has established a training provider certification process.

Currently, approximately seven states have established by statute, regulation or guideline, a risk-based decontamination standard specific to methamphetamine. Those states include Alaska, Arizona, Arkansas, Colorado, Minnesota, Tennessee, and Washington. The two most commonly provided measurements are $0.1\mu g/100cm^2$ and $0.5\mu g/ft^2$. There is an ongoing debate about the effectiveness of using a risk-based standard. Because research into the long-term health effects associated with clandestine laboratories has just recently begun, a health-based standard has not been determined yet. Thus, states are relying on the limited research available to determine the appropriate risk-based standard that must be met by a cleanup contractor and/or industrial hygienist in order to certify that a property has been decontaminated.

There are also several notice issues involved in the cleanup and remediation of properties contaminated by clandestine laboratories. A few states have statutory and/or regulatory provisions that require a particular agency to maintain a list of contaminated properties and/or a list of certified contractors that must be available to the public. A

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

property is generally removed from the contamination list once it is certified by the appropriate entity as decontaminated. Another issue relates to the notifying of the county recorder's office that a property has been deemed contaminated. In Washington, the local health officer is required to file a copy of an order prohibiting the use of a property with the county auditor. If, after the remediation process is complete, the local health officer determines that the property has been decontaminated, he/she is required to record a release for reuse document in the real property records of the county auditor where the property is located. The county auditor provisions are located within the purview of the chapter on the decontamination of illegal drug manufacturing or storage sites. Additional states may have similar statutory and regulatory provisions relating to the recording of property contamination in other parts of the state code.

Numerous states have become concerned with presently or formerly contaminated properties being sold, transferred, or rented without the buyer or occupant being made aware of the status of the property. Such disclosure issues and restriction on the transfer of the property have been addressed in many different areas of the state code. Arizona, Alaska, and Oregon, in particular, address this issue within the purview of their cleanup laws and regulations. The statutes and/or regulations generally require the seller to notify the buyer in writing that illegal drug manufacturing occurred on the premises. A buyer then may cancel the purchase contract within a certain number of days after receiving notice of the property's status. In Oregon, if the seller fails to properly notify the buyer, the buyer may bring suit to recover damages for any losses. In Arizona, the seller is subject to civil penalties for any harm that was caused for his/her failure to comply with its notice requirements.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

As mentioned earlier, numerous local governments (i.e., cities and municipalities) have passed ordinances that relate to the cleanup of methamphetamine laboratories. Some of the ordinances address nuisance and local building code issues. Other ordinances address cleanup and remediation directly. Ordinances can be found both in states that already have related statutes and regulations as well as in states that have not yet addressed the issue at the state level.

The following state cleanup and remediation information includes summaries of cleanup and remediation statutes, regulations, ordinances, and guidelines that we have located in our research. We have also provided a list of the websites for several states that contain what we have defined as "guidance documents." In addition, you will find a directory for examples of different provisions of cleanup and remediation statutes, regulations, and local ordinances. Hard copies of the selected provisions are provided in this binder. In order to view the full cleanup provisions from any of the included states please see the CD-Rom.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# ALASKA

**Citations: ALASKA STAT. §§ 46.03.500 to -599 (Michie 2003).**

***Please note that the effective date of the laws cited above and discussed below is contingent on the effective date of the initial regulations adopted by the Alaska Department of Environment Conservation.**

**Alaska Dep't of Envtl. Conservation, *Guidance and Limits for Cleanup of Illegal Drug-Manufacturing Sites at*** http://www.state.ak.us/dec/spar/perp/docs/druglab_guidance.pdf **(last visited October 5, 2004).**

**Summary:**

Alaska has recently enacted a law relating to the evaluation and cleanup of sites where certain controlled substances may have been manufactured or stored. The law defines an "illegal drug manufacturing site" as a property on which there is reasonable cause to suspect contamination with chemicals associated with the manufacturing of a controlled substance and where activity involving the unauthorized manufacture of a controlled substance listed on schedule I or II or a precursor chemical or necessary chemical for the substances has occurred; or there are kept, stored, or located any of the devices, equipment, things, or substances used for the unauthorized manufacture of controlled substances listed on schedule I or II.

Under this law, after a law enforcement officer (qualified under federal regulations to investigate and dismantle illegal drug manufacturing sites) determines that a site constitutes an illegal drug manufacturing site, the primary law enforcement agency that conducted the investigation is responsible for notifying the property owner, the occupants or the users of the property, and the Department of Environmental

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

Conservation (DEC). The property itself is then posted with a statement that it may pose a substantial risk of physical harm to persons who occupy or use the property. The property owner is responsible for securing the premises.

If the owner desires to decontaminate the property, the owner is directed to follow the guidelines established by the DEC. According to the law, once decontamination is complete, the owner is required to certify that the site has been sampled and tested using procedures and laboratory services that have been established by the DEC and that the limit on substances (as specified in regulations to be adopted under this law) is not exceeded on the property. The DEC is required to maintain a list of properties for which it has received notice of an illegal drug manufacturing site, and once a property is certified as fit for use, the DEC is then required to remove the property from the list and notify the owner.

In addition to the previously mentioned details, the Alaska law addresses the transfer, sale, use or rent of property used as illegal drug manufacturing sites in their cleanup laws. The transfer, sale, use or rent of such property is restricted and full disclosure is required.

The DEC has drafted regulations as required by the above discussed law. Those regulations were recently up for public comment and have not been adopted yet. The DEC currently has guidelines entitled "Guidance and Limits for Cleanup of Illegal Drug-Manufacturing Sites." The guidelines list several cleanup standards, including a standard of $0.1\mu g/100cm^2$ for methamphetamine. It is recommended by the guidelines that a cleanup contractor who is equipped to perform hazardous chemical remediation be utilized to handle the decontamination. In addition, the guidelines cover decontamination

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

protocols (i.e., ventilation and encapsulation procedures), post-cleanup sampling and testing procedures (i.e., wipe-sampling, vacuum sampling, volatile organic compound sampling, and mercury sampling), waste management, and several different types of field-screening methods.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# ARIZONA

**Citations: ARIZ. REV. STAT. ANN. §§ 12-990, 12-1000 to 1001, 32-101, 32-112, 32-141 (West 2004).**
**ARIZ. ADMIN. CODE R.4-30-103, -270 to -272, -305 (2004).**

**Summary:**

Arizona defines, by statute, a "clandestine drug laboratory" as real property on which methamphetamine, ecstasy or LSD is being manufactured or where a person is arrested for having on any real property chemicals or equipment used in manufacturing methamphetamine, ecstasy or LSD. The definition also includes any space rental mobile home or recreational vehicle park in which methamphetamine, ecstasy or LSD is being manufactured or where a person is arrested for having chemicals or equipment used in manufacturing methamphetamine, ecstasy or LSD in the mobile home or recreational vehicle. Upon the discovery of or an arrest at a clandestine drug laboratory by a peace officer, that peace officer is responsible for the delivery of a notice of removal to certain parties. Those parties include: the owner of the real property, the on-site manager of a property, or the occupant of a tenant-owned unit, and both the county health department and the appropriate fire department. A notice that states information on the status of the property and prohibits entry onto the contaminated portion of the property is also required to be posted in a conspicuous place on the real property

Pursuant to statute, a law enforcement or other agency may remove gross contamination found on the property. Gross contamination is defined as the chemicals, equipment and other items found in a clandestine drug laboratory. The owner is then

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

required to immediately remediate the residually contaminated portion of the real property by retaining a registered drug laboratory site remediation firm (hereinafter referred to as "the firm"). The firm is required to be registered with the state, have properly certified supervisors and workers, and it must comply with the best practices and standards for remediation or residual contamination that were adopted by the Board of Technical Registration.

In order to obtain registration, the firm must provide, for example, the name of the on-site supervisor who is authorized and responsible for the services being offered and a copy of a current license issued by the state Registrar of Contractors. The registration must be renewed annually. With regard to the firm's on-site supervisor/worker certification, the employees that work on the drug laboratory site are required to have completed several federally regulated training courses as well as an 8-hour training course specific to clandestine drug laboratories that is approved by the Board of Technical Registration. On-site supervisor/worker certification must also be renewed annually.

According to Arizona regulations, the on-site supervisor of the firm responsible for the cleanup is required to do the initial testing and assessment of the contaminated property. Once complete, the firm is then required to prepare a written work plan that includes health and safety procedures that will be followed during the remediation, a detailed summary of the work to be performed, a list of the proposed post-decontamination tests for the property with the name of the individual conducting the sampling and the laboratory performing the analytical testing, etc. The written work plan is required to be approved by the owner and submitted to the county health department.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

The drug laboratory site remediation best standards and practices, which can also be found in regulation, include procedures for remediating the inside areas of the drug laboratories that have different levels of contamination. It also provides procedures for testing the plumbing, septic system, sewer, and soil at the site. Any potentially impacted soil and/or groundwater is required to be investigated under the direct supervision of an Arizona-registered geologist or engineer. Once the firm has completed the remediation process, post-remediation testing is required to be conducted under the direct supervision of a Certified Industrial Hygienist, a Certified Safety Professional, or an Arizona-registered geologist or engineer. The regulations contain both sampling procedures and remediation standards. In particular, the remediation standard for methamphetamine is $0.1\mu g/100cm^2$. The firm is required to submit a final report once all the post-remediation testing is complete.

In addition, Arizona addresses the issue of the sale or transfer of real property that has been used as a clandestine drug laboratory in their cleanup laws. The sale or transfers of such properties are restricted and certain disclosures are required.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# ARKANSAS

**Citations: ARK. CODE ANN. § 20-7-132 (Michie 2003).**
**Arkansas Dept. of Health, *Clandestine Methamphetamine Laboratory Cleanup Guidelines, at* http://www.healthyarkansas.com/pdf/adh_methguidelines_2004.pdf (last visited August 26, 2004).**

**Summary:**

In 2003, the Arkansas Department of Health was mandated by statute to develop guidelines for the cleanup of former clandestine methamphetamine drug labs by April 1, 2004. Currently, there are no state statutes that authorize state or local entities to require the cleanup of properties contaminated by clandestine drug laboratories. The guidelines provide only suggestions as to how to handle indoor contamination.

With respect to cleanup contractors, no specific information is provided in the guidelines. Property owners are suggested to use diligence in hiring a contractor. A pre-assessment identification of contaminated areas is the first advised step in the process. Then it is recommended that a cleanup protocol be developed and approved by the property owners or their representatives and the cleanup contractor. The protocols should address worker safety according to Occupational Safety and Health Administration regulations and guidelines, removal of items to be disposed of or cleaned, washing all surfaces of likely contamination, and taking surface wipe samples and testing for methamphetamine or other contaminants.

The guidelines also provide suggestions on post-cleanup sampling for determining the adequacy of the cleanup of the contamination. In particular, the guidelines address surface sampling for methamphetamine and recommend that $0.5\mu g/ft^2$ of methamphetamine residue in a sample area is an acceptable post-cleanup re-occupancy

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

level for a structure. The guidelines note that $0.5\mu g/ft^2$ is the most commonly used decontamination standard by other states and that there is still a lack of scientific information about the adverse health affects of long-term exposure to low-levels of methamphetamine.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# CALIFORNIA

**Summary:**

Although California has been dealing with clandestine laboratories for many years, they do not currently have any statutes, regulations, or guidelines that specifically address the remediation of properties contaminated by the clandestine laboratories.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# COLORADO

**Citations: H.B. 1182, 64TH Gen. Assem., 2d Reg. Sess. (Co. 2004).**
**Colorado Dep't of Public Health and Environment, *Cleanup of Clandestine Methamphetamine Labs Guidance Document, at*** http://www.cdphe.state.co.us/hm/methlab.pdf **(last visited August 27, 2004).**

**Summary:**

Colorado has recently enacted a new law regarding standards for the cleanup of illegal drug laboratories. According to the new statutory provisions, the Board of Health in the Department of Public Health and Environment is mandated to promulgate rules that establish acceptable standards for the cleanup of illegal laboratories used to manufacture methamphetamine. The Board must consider the findings of the Hazardous Materials and Waste Management Division of the Department of Public Health and Environment (Department) in the July 2003 report entitled "Cleanup of Clandestine Methamphetamine Labs Guidance Document." The new law further requires property owners, once notified by a peace officer that chemicals, equipment, or supplies indicative of an illegal drug laboratory are located on the property, to meet the cleanup standards established by the Board or may, at his or her own option, demolish the contaminated property instead.

The statutory provisions include the definition of "drug laboratory" as the areas where controlled substances, as defined in the Colorado Revised Statutes, have been manufactured, processed, cooked, disposed of, or stored and all proximate areas that are likely to be contaminated as a result of such activities. The term "property" is defined as anything that may be subject to ownership, including, but not limited to, land, buildings, structures, and vehicles.

The "Cleanup of Clandestine Methamphetamine Labs Guidance Document" initially discusses the need for a preliminary site assessment. The site assessment should be reviewed

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

by a local health department, or other oversight agency, to evaluate the potential contamination and health risk. The oversight agency will determine whether a property is fit for use and whether cleanup and remediation are necessary. If indoor cleanup and remediation is necessary, the guidance document includes information on cleanup procedures for the ventilation and plumbing systems and non-porous and semi-porous surfaces.

Once the cleanup is complete, the guidance document recommends that a post-cleanup assessment for the structure should be conducted under the supervision of a person such as a Certified Industrial Hygienist. It provides information on wipe sampling procedures and appropriate remediation levels. The guidance document notes that risk-based exposure limits for the remediation standards have been provided because there is no sufficient information available regarding the health risks associated with long-term exposure to low level concentrations of methamphetamine. Thus, the risk-based remediation standard provided is $0.5\mu g/ft^2$. The document also contains, for example, OSHA and National Institute for Occupational Safety & Health exposure limits for chemicals associated with clandestine methamphetamine labs.

In addition, the guidance document provides sampling and analytical methods for contamination detection in soil, groundwater and surface water. Specifically, it provides soil remediation objectives as established by the Hazardous Material and Waste Management Division and groundwater cleanup standards as established by the state Water Quality Control Commission. The guidance document also recommends that cleanup of outdoor areas affected by former methamphetamine labs should be conducted by a professional environmental contractor, in consultation with the Department's Hazardous Materials and Waste Management Division.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# FLORIDA

**Citation: FLA. STAT. ANN. §§ 403.413, 403.703 (West 2004).**

**Summary:**

According to law enforcement contacts in Florida, they currently use litter laws in an effort to combat illegal drug manufacturing sites. Litter is defined as any garbage, rubbish, trash, refuse, can, bottle, box, container, paper, tobacco product, tire appliance, mechanical equipment or part, building or construction material, tool, machinery, wood, motor vehicle or motor vehicle part, vessel, aircraft, farm machinery or equipment, sludge from a waste treatment facility, water supply treatment plant, or air pollution control facility, or substance in any form resulting from domestic, industrial, commercial, mining, agricultural, or governmental operations.

The Florida Litter Law prohibits the dumping of litter in any manner or amount in or on any private property, unless prior consent of the owner has been given and unless such litter will not cause a public nuisance or be in violation of any other state or local law, rule, or regulation. Any person who dumps litter which is hazardous waste is guilty of a felony of the third degree. Hazardous waste is currently defined by statute as solid waste, or a combination of solid wastes, which, because of its quantity, concentration, or physical, chemical, or infectious characteristics, may cause, or significantly contribute to, an increase in mortality or an increase in serious irreversible or incapacitating reversible illness or may pose a substantial present or potential hazard to human health or the environment when improperly transported, disposed of, stored, treated, or otherwise managed. A court may order the violator to remove or render harmless the litter that he

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

or she has dumped, to repair or restore property damaged by, or pay damages for any damage arising out of his or her dumping litter.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# IOWA

**Citation: IOWA CODE ANN. §§ 124C.1 to 124C.7 (West 2004).**

**Summary:**

Iowa currently has a chapter in its state code entitled "Cleanup of Clandestine Laboratory Sites." The statutory provisions define a clandestine laboratory site as a location or operation, including but not limited to buildings or vehicles equipped with glassware, heating devices, and precursors or related reagents and solvents needed to unlawfully prepare or manufacture controlled substances. The term "cleanup" is defined as actions necessary to contain, collect, control, identify, analyze, disassemble, treat, remove, or otherwise disperse all substances and materials, including but not limited to those found to be hazardous waste and controlled substances as defined by the state code, including contamination caused by those chemicals or substances.

The statutory provisions provided in this chapter address funding and liability issues related to the cleanup of clandestine laboratory sites. The provisions do not address contractor certification, cleanup methods, remediation standards, etc.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# KANSAS

**Summary:**

Currently, Kansas does not have any state laws requiring the cleanup of clandestine drug laboratories. According to the Kansas Department of Health (KDOH) and Environment, the Voluntary Cleanup and Property Redevelopment Program as well as state specific risk-based remediation standards that have been developed by the KDOH have been utilized to clean up clandestine drug lab sites. Both the program and the risk-based standards apply to the remediation of contaminated sites in general and are not specific to clandestine drug lab sites.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# MINNESOTA

**Citations: Minnesota Dep't of Health, *Clandestine Drug Labs General Cleanup Guidelines, at* http://www.health.state.mn.us/divs/eh/meth/lab/cleanup0903.pdf (last visited September 1, 2004).**
**Olmsted County, Minn., Resolution 01-99 (Oct. 23, 2001).**
**Dakota County, Minn., Ordinance 129 (May 6, 2003).**
**CITY OF OAKDALE, CODE OF ORDINANCES ch. 18, art. IV, §§ 18-16 to 18-28 (2004).**

**Summary:**

Currently, Minnesota state law does not require private property owners to clean up and remediate clandestine drug laboratory sites. Guidance for lab cleanup, however, can be found in the Minnesota Department of Health's (MDH) "Clandestine Drug Labs General Cleanup Guidelines." The guidelines provide suggestions for assessing the property condition, site cleanup and disposal, sampling methods, and remediation levels.

With regard to cleanup contractors, the MDH lists contractors on its website that are experienced hazardous materials contractors who have agreed to conduct remediation activities in accordance with these guidelines. Before entering a site, the guidelines suggest that the contractor create a Site Entry Plan that documents hazard potential for acute chemical exposure. Once the entry onto the site is made according to the plan, a preliminary assessment of the contamination should be made by the cleanup contractor or a local health officer. The objectives of the preliminary assessment include determining: (1) the type of process used, (2) whether mercury or lead was used, (3) the scope of testing or remediation needed, and (4) whether habitable structures are safe for occupancy. At the completion of the preliminary assessment, a work plan is

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

recommended that includes a site map showing the location of contamination and sampling points, and preliminary and final testing plans.

The guidelines suggest several indoor contamination testing methods for items such as the plumbing fixtures and porous, semi-permanent furnishings. Other testing may include indoor ambient quality and the evaluation and remediation of chemical spills and residues. Where there are signs of outdoor contamination, the guidelines recommend that the Minnesota Pollution Control Agency and other appropriate regulatory agents be contacted. Methods for outdoor sampling are provided for locations such as septic systems and soil near the drug laboratory site.

After indoor and outdoor remediation are complete, post-cleanup sampling and testing is recommended in order to determine if the cleanup of the contamination is adequate. The guidelines provide remediation standards for several different chemicals commonly found at a clandestine drug laboratory. In particular, the guidelines provide remediation levels for methamphetamine, pseudoephedrine and ephedrine of less than $1\mu g/ft^2$. Once the testing is complete, a final report should be made that includes written documentation that work proceeded according to plan and that the contamination has been reduced to acceptable levels.

In addition to the guidelines discussed above, many of Minnesota's cities and counties have passed ordinances to help deal with the cleanup of clandestine drug lab sites. For example, both Dakota and Olmstead Counties require a law enforcement agent who discovers a clandestine lab site to deem it as a "chemical investigation site public health nuisance." The law enforcement agent must then give notice to the local Public Health Authority. The Public Health Authority is required to provide notice to the

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street; Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

owner/occupant of their responsibilities related to the cleanup. Those responsibilities include: notifying the local health authority that the property will remain vacated and secured until the public health nuisance no longer exists; hiring an acceptable contractor that has been approved by the MDH or the local health department; and providing the local health authority with the contractors work plan that details the on-site indoor and outdoor cleanup process to be completed, as well as follow-up testing that demonstrates that appropriate remediation levels are met according the MDH's guidelines.

The City of Oakdale, located in Washington County, MN, requires the law enforcement agent who discovers a clandestine drug lab site or an associated chemical dumpsite, to notify the City Building Official. The City Building Official will then issue and post on the structure a "Declaration of Public Health Nuisance." The Building Official is also required to issue an order to the property owner to abate the public health nuisance. The property owner's responsibilities are similar to the ones mentioned above in the county ordinances.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# MISSOURI

**Citation: MO. ANN. STAT. § 640.040 (West 2004).**

**Summary:**

The Missouri Department of Natural Resources (DNR) has the statutory authority to provide the resources and personnel to assist in the cleanup and disposal of the hazardous substances, including, but not limited to, chemicals intended for use in or resulting from the manufacture of controlled substances. The DNR also has the authority to adopt rules as necessary for the implementation and operations of such actions. Currently, no rules have been adopted that address this issue.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# NEW MEXICO

**Citation: ALBUQUERQUE, N.M., CODE OF ORDINANCES, ch. 11, art. I, subpart D (2004).**

**Summary:**

Although New Mexico does not have any state laws or regulations that address the cleanup and remediation of clandestine drug lab sites, the City of Albuquerque, NM, has recently enacted an ordinance entitled "Cleanup of Clandestine Drug Laboratory Sites Ordinance." The ordinance defines a "clandestine drug laboratory" as real property on which methamphetamine, ecstasy, LSD or any other controlled substance is being manufactured or on which there is an attempt to manufacture, or where a person is arrested for having on any real property any chemicals or equipment used in manufacturing methamphetamine, ecstasy, LSD or any other controlled substance. The term also includes any space rental mobile home or recreational vehicle park in which methamphetamine, ecstasy, LSD or any other controlled substance is being manufactured or where a person is arrested for having chemicals or equipment used in manufacturing methamphetamine, ecstasy, LSD, or any other controlled substance in the mobile home or recreational vehicle. Further, the ordinance defines a "clandestine drug laboratory" as any place or area where chemicals or other waste materials used in clandestine drug laboratories have been located.

Upon the discovery of or an arrest at a clandestine drug laboratory by a law enforcement officer, the law enforcement officer is responsible for the delivery of a notice of removal to certain parties. Those parties include: the owner of the property, the on-site manager of the property, the occupant of a tenant-owned unit, or the on-site park

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

landlord, and both the Albuquerque Environmental Health Department and the Albuquerque Fire Department. The notice of removal which states information on the status of the property and prohibits entry onto the contaminated portion of the property is also required to be posted in a conspicuous place on the real property. The law enforcement officer is responsible for filing a Certificate of Substandard Property with the Bernalillo County Assessor.

The owner of the property is required to remediate the residually contaminated portion of the property by retaining an industrial or environmental hygienist firm to pre-test the property to determine the extent of the contamination and the nature of the required remediation. The firm must notify the owner that remediation is necessary and the owner is then required to send such notification to the Albuquerque Police Department, the City Environmental Health Department, and the City's Chief Building Official. Next, the owner must retain a drug laboratory site remediation firm. This firm must be separate and unaffiliated with the industrial or environmental hygienist firm. Both firms must comply with the best practices and standards for remediation of residual contamination adopted by the Albuquerque Police Department and the City Environmental Health Department. .

Once remediation is complete, the drug laboratory site remediation firm is required to notify the Albuquerque Police Department, the City Environmental Health Department, and the industrial or environmental hygienist firm that the property is ready for final inspection. Upon the completion of inspection by the industrial or environmental hygienist firm and approval by the Albuquerque Police Department and the City Environmental Health Department, the industrial or environmental hygienist

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

firm will issue a final clearance document certifying that the remediation is complete pursuant to the proper remediation standards. The owner is responsible for providing a copy of the certification to the required parties as listed in the ordinance. The above listed procedure also applies to the remediation of contaminated vehicles.

In addition, the issue of transfer of property used as illegal drug manufacturing sites is addressed in the ordinance. Transfer of such property to buyers is restricted and full disclosure to buyers and occupants is required. See the ordinance for details.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# NEW YORK

**Citation: City of Elmira, NY, Local Law No. 1 of 2004 (July 12, 2004).**

**Summary:**

Although New York does not have any state statutes or regulations related to the cleanup and remediation of clandestine drug lab sites, the City of Elmira has recently addressed the issue through local law. The local law addresses the public nuisance created by the use of commercial and residential property for the manufacture or attempt to manufacture methamphetamine or amphetamine.

The term "public nuisance" is defined as any premises on or in which there occurs or which is used in any manner in the illegal manufacture or attempt to illegally manufacture methamphetamine or amphetamine and on or in which is found ephedrine, norpseudoephedrine, N-Methylephedrine, N-Methylpseudoephedrine, or pseudoephedrine while a the same also possessing any of the following: amorphous (red) phosphorus or white phosphorus; hydroiodic acid; anhydrous ammonia; sodium; or lithium; or phenylalanine. If a public nuisance, as defined previously, exists on the premises, the City Manager may issue a temporary order directing the immediate closure of the premises or any portion thereof. Notice and opportunity shall be provided to all those who have an interest in the premises.

Once the City Manager determines that closure of the premises is necessary, he or she will issue an order of closure that is mailed to the owner and posted on the property itself. The City Manager may also issue an order to the owner and/or occupant of the premises to immediately abate the public nuisance. If the order is issued, the owner and/or occupant are required to promptly acquire the appropriate environmental testing and remediation of the nuisance. Written documentation is required that includes a statement from the remediation

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

contractor that the premises is safe for human occupancy and that the remediation was conducted in accordance with the laws of the State of New York. If an owner does not take appropriate testing and remediation measures, the City may then perform such testing and remediation measures. All expenses incurred by the City for the cleanup process are the responsibility of the owner or occupant of the premises and if the owner fails to pay the costs, the City may recover the costs by civil action against the owner and the adult occupants, and such costs shall become a lien on the premises.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# NORTH CAROLINA

**Citation: S.B. 1054, 2003 Gen. Assem., Sess. 2004 (N.C. 2004).**

**Summary:**

On August 3, 2004, the North Carolina state legislature enacted a statute that relates to the decontamination of property used for the manufacture of methamphetamine. Essentially, the statute provides the North Carolina Commission for Health Services (Commission) with the authority to adopt rules that establish decontamination standards to ensure that a property is reasonably safe for habitation. Such rules will apply to an owner, lessee, operator or other person in control of a residence or place of business or any structure appurtenant to a residence or place of business, and who has knowledge that the property has been used for the manufacture of methamphetamine. The Commission is currently drafting rules pursuant to this new statute and expects the rules to be in effect as of January 1, 2005.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# OREGON

**Citations: OR. REV. STAT. §§ 453.855 to -995 (2003).**
**OR. ADMIN. R. §§ 333-040-0010 to -0230, 918-010-0000 to -0025 (2004).**
**LANE COUNTY, OR., LANE CODE §§ 5.700 to 5.990 (2004).**

**Summary:**

Under Oregon's cleanup laws, an illegal drug manufacturing site is defined as any property on which there is a reasonably clear possibility of contamination with chemicals associated with the manufacturing of controlled substances, including any activity involving the unauthorized manufacturing of a Schedule I or II controlled substance, any precursor chemical for such substance, and any place where the devices, equipment, etc. are kept. The term "property" is defined as any real property (including improvements on real property or portions of the improvements), a boat, trailer, motor vehicle, or manufactured dwelling.

A property may be determined as unfit by the Director of Human Services or a designee thereof, the State Fire Marshal or a designee thereof, or any law enforcement agency. Once a determination is made, the agency designating the property unfit for use must notify the owner of the property and the Department of Human Services (DHS), and post warning notices on the contaminated property. DHS must then notify the Director of the Department of Consumer and Business Services (DCBS). DCBS is required to list the property as not fit for use until otherwise notified by the Department of Human Services (DHS). The owner is responsible for preventing reasonable means to the entry, occupancy or any use by anyone of the property until the property has been issued a Certificate of Fitness by DHS. If an owner allows use of the property, it shall be

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

considered as maintaining a public nuisance subject to being enjoined or abated under state law.

If a property owner desires interior and exterior decontamination of their property, the services of a contractor licensed by DHS, or upon approval by DHS, the owner, or an agent of the owner, may perform the decontamination work. The contractor is responsible for performing a site assessment, supervising site sampling by an independent third party, submitting a work plan for DHS approval, and decontaminating the property or supervising the decontamination of the property. Once the work plan is approved and the decontamination work is completed according to the plan and is properly documented, DHS will certify the property as having been decontaminated. According to DHS, the remediation standard for methamphetamine, although not found in statute or regulation, is a policy standard of 0.5 $\mu g/ft^2$.

The property owner is responsible for notifying DCBS of the certification in order for the property to be removed from the list. DHS may contract with state or local agencies or private persons to perform any inspection or to obtain any samples relative to determining the adequacy of decontamination work. DHS is required by statute to evaluate annually a number of the property decontamination projects performed by licensed contractors. If a project fails inspection, the contractor is subject to civil penalties and license suspension.

Under statutory authority, DHS has promulgated rules regarding the specifics of contractor and employee licensing, training, and performance standards. DHS may deny, suspend or revoke the license of any contractor that fails to: (1) perform decontamination work under the supervision of trained personnel, (2) file a work plan, (3) perform work

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

pursuant to the plan, or (4) commits fraud or misrepresentation in applying for a license, seeking approval of a work plan, or documenting completion of the work to DHS.

As mentioned above, DHS is required to provide lists of the name of their licensed contractors to DCBS. DCBS is then required to distribute the lists to local building code enforcement agencies. Pursuant to statutory authority, DCBS has adopted rules that create uniform standards whereby local building code enforcement agencies may require that property determined to be not fit for use may be subject to action to condemn or demolish the property or to require the property be vacated or contents be removed from the property. According to contacts in Oregon, some cities and counties currently utilize their nuisance ordinances in concert with the state statutes and regulations to deal with illegal drug manufacturing sites.

In addition, Oregon addresses the transfer, sale, use or rent of property used as illegal drug manufacturing sites in their cleanup laws and regulations. The transfer, sale, use or rent of such property is restricted and full disclosure is required.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# TENNESSEE

**Citations: 2004 Tenn. Pub. Acts Ch. 855.**
**TENN. COMP. R. & REGS. tit. 1200, ch.1-19 (2004).**
**Tenn. Dept. of Evn't & Conservation, *Reasonable, Appropriate, Protective Cleanup Response and Documentation Guidelines for Properties Quarantined due to Clandestine Laboratory Activities, at* http://www.state.tn.us/environment/dsf/meth/ (last visited September 13, 2004).**

**Summary:**

On June 8, 2004, the Tennessee legislature enacted a new law requiring the Commissioner of the Department of Environment and Conservation (DEC) to compile and maintain a list of certified industrial hygienists as well as a list of persons authorized to perform cleanup of hazardous waste sites, that include but are not limited to property used to manufacture methamphetamine. The law declares that the combination of substances necessary for the manufacture of methamphetamine creates a hazardous substance. Further, the law states that any property, or any structure or room in any structure on any property wherein the manufacture of a controlled substance is occurring or has occurred, may be quarantined by the local law enforcement agency where the property is located. The law enforcement agency is then responsible for posting signs indicating that the property has been quarantined and, to the extent possible, for notifying all parties having any right in the property.

Once the property has been quarantined, a party having a right in the property may contact either a certified industrial hygienist or other person certified as qualified by the Commissioner to determine whether hazardous waste is present on the property and perform cleanup and removal if necessary. The certified industrial hygienist or other

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

qualified person must certify that the property is "Safe for Human Use" once cleanup is completed.

With regard to cleanup standards, the law authorizes the Commissioner of DEC to promulgate rules concerning inspection, testing and quarantine of the property. On August 18, 2004, the Commissioner of DEC adopted emergency rules providing standards for testing and cleaning clandestine drug manufacturing sites. In particular, the rules provide a remediation standard for methamphetamine that cannot exceed $0.1\mu g/100cm^2$. The rules also reiterate the statutory requirements regarding the use of professionals certified by the Commissioner of DEC for sampling and cleanup.

In addition to the rules, the DEC has provided interim guidelines entitled "Reasonable, Appropriate, Protective Cleanup Response and Documentation Guidelines for Properties Quarantined due to Clandestine Drug Laboratory Activities." These guidelines focus mainly on indoor contamination cleanup procedures. According to the guidelines, once the criminal investigation is complete, the property owner should contact a cleanup contractor. The cleanup contractor is required to review the crime scene report and inspect the quarantined property, assess all potential hazards, and assign the appropriate cleanup response based on four different tiers developed by DEC. Each tier outlines the type of decontamination procedure necessary based on the extent of production of methamphetamine or its precursors that has occurred, the extent of staining, the amount of spills, etc.

Once the appropriate tier response is selected by the cleanup contractor, the contractor must then develop a "Scope of Work" for the cleanup activities. The guidelines provide a process for the collection of non-porous surface samples and suggest

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

that with the exception of screening samples, sample collection should be performed after the cleanup is complete. Once the decontamination is finished and the sample collection is performed and the samples are tested, the contractor must submit a written report that includes justification for the process used and verification that the cleanup was done according to the "Scope of Work." Before and after photo documentation must be submitted as well as the "Transportation and Disposal Plan" if removal activity occurred. Lastly, as mentioned above, the cleanup contractor is to submit a letter certifying that the quarantined property has been cleaned up and that all risks and hazards resulting from criminal methamphetamine production have been abated, and that the property is "Safe for Human Use."

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION**

# UTAH

**Citation: UTAH CODE ANN. §§ 19-6-901 to 19-6-906, 26A-1-121 (2004).**

**Summary:**

The Utah legislature has recently passed the "Illegal Drug Operations Site Reporting and Decontamination Act." The law requires any state or local law enforcement agency that observes any paraphernalia of a clandestine drug laboratory operation to report the location where the items were observed to the local health department. The local health officer or his designee is responsible for determining if reasonable evidence exists that the property is contaminated. If the property is determined to be contaminated, the local health department must place the property on a contamination list, notify the owner of record of his/her property status, and provide information on remediation options and requirements necessary to cleanup up the property.

The owner of the property must, by a deadline specified in the notification, provide to the local health department information on how the owner plans to address the contamination. The owner is required to meet certain remediation standards in order to have the property removed from the contamination list. A certified decontamination specialist (an individual who has met standards for certification as a decontamination specialist and has been certified by the Solid and Hazardous Waste Control Board) may be utilized. The specialist is required to report to the local health department of any property that is the subject of decontamination work. The report should include information about the location of the property and a proposed work plan for

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

decontaminating the property. Once the cleanup process is complete, the specialist is required to submit a report to the local health department certifying that the property is decontaminated. The local health department may then remove the property from the contamination list.

The law authorizes the state Department of Health, in consultation with the local health departments and the Department of Environmental Quality, to establish when testing is required, the decontamination and sampling standards, and appropriate methods for testing indoor and outdoor areas that may be contaminated. In addition, the Solid and Hazardous Waste Control Board, in consultation with the Department of Health and local health departments, is authorized to establish within the Department of Environmental Quality Division of Environmental Response and Remediation certification standards for the decontamination specialists and a process for revoking the certification of a decontamination specialist who fails to meet certification standards. Please note that there are several local cleanup related ordinances that were in place prior to the passing of this new state law. The effect of this new state law and the regulations currently being developed on these local ordinances is under review.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

STATE ENVIRONMENTAL CLEANUP AND REMEDATION INFORMATION

# WASHINGTON

**Citations:** **WASH. REV. CODE ANN. §§ 64.44.005 to -901, 69.50.511, 70.105D.070 (West 2004).**
**WASH. ADMIN. CODE §§ 246-205-001 to -131, 246-205-510 to -990, 296-62-3040 to -30465 (2004).**
**Washington State Dep't of Health, *Guidelines for Environmental Sampling at Illegal Drug Manufacturing Sites, at*** http://www.doh.wa.gov/ehp/ts/CDL/cdl- envir-sampling.pdf **(last visited September 27, 2004).**

**Summary:**

Washington has the country's most comprehensive set of laws specifically related to environmental cleanup of properties contaminated by illegal drug manufacturing. Types of properties covered by the state cleanup laws and regulations include any site, structure, or part of a structure which is involved in the unauthorized manufacture or storage of hazardous chemicals. Some examples are single-family residences, units of multiplexes, condominiums, apartment buildings, boats, motor vehicles, trailers, manufactured housing, or any shop booth, or garden. Once a law enforcement agency or property owner becomes aware that a particular property has been contaminated by hazardous chemicals, they are required to report the contamination to a local health officer and the state department of ecology.

The local health officer has several obligations under the law after a possible contamination is reported. Generally, these obligations include posting a warning on the property, inspecting the property, determining whether contamination exists, reporting the contaminated property to the state department of health (DOH), sending notification of the contaminated property to occupants or persons having interest in the property, determining whether a certified contractor is required for decontamination, verifying decontamination was performed properly, and recording a release for use document once the property is

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

determined to be decontaminated. If the local health officer determines that a contractor is required, the property owner must use the services of a contractor certified by the DOH unless otherwise authorized. The DOH is required to keep a list of all contaminated properties and certified contractors.

Pursuant to statutory authority, the DOH has developed regulations regarding training and certification of contractors and their employees. The DOH has also established performance standards for certified contractors. Such standards include performing all decontamination work only with department certified workers and supervisors, filing a work plan with and obtaining approval from the local health department, complying with all applicable federal and state statutes and regulations, and notifying the state and local jurisdictional health department of all work performed within 10 days of completion. A denial, suspension, or revocation of certification and civil penalties may be assessed if the contractor fails to perform decontamination, demolition, or disposal work under the supervision of trained personnel, fails to file a work plan or fails to perform work pursuant to a work plan, fails to perform work that meets requirements of the department, or obtains certification by error, misrepresentation, or fraud.

With regard to decontamination, the DOH has provided guidance through regulation and guidelines. A DOH document entitled "Guidelines for Contamination Reduction and Sampling at Illegal Drug Manufacturing Sites" gives information on the cleanup of both indoor and outdoor contamination at illegal drug manufacturing sites. In particular, the guidelines include methods for obtaining methamphetamine wipe samples, wastewater samples, soil samples, sampling for corrosives, and water samples. They also address field quality control methods, chain of custody issues, and decontamination procedures for the personal protective equipment used. Both the regulations and guidelines provide chemical

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

detection levels for determining whether a property has been decontaminated, including a remediation standard of $0.1\mu g/100cm^2$ for methamphetamine.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# CLEANUP AND REMEDIATION OF METHAMPHETAMINE LABORATORIES GUIDANCE DOCUMENTS

****Please note that a number of states have put together guidelines or guidance documents for the cleanup and remediation of methamphetamine laboratories. We have defined certain documents as guidelines based on the content provided. Documents we are considering guidelines are those that contain detailed scientific sampling information and remediation standards for methamphetamine. We have considered the documents below as "guidance documents" because they tend to be less detailed in nature and do not address a remediation standard for methamphetamine.**

Illinois Department of Public Health, Environmental Health, *Fact Sheet: Methamphetamine Laboratories and Cleanup, at* http://www.idph.state.il.us/envhealth/factsheets/meth-labs.htm (last visited September 27, 2004).

Illinois Department of Public Health, Environmental Health, *Fact Sheet: Guidelines for Cleaning Up Former Methamphetamine Labs, at* http://www.idph.state.il.us/envhealth/factsheets/meth-cleanup.htm (last visited September 27, 2004).

Kansas Department of Health and Environment, Division of Environment, *Cleaning Up Former Methamphetamine Labs, at* http://www.kdhe.state.ks.us/methlabs/ml_cleanup.html (last visited September 27, 2004).

Missouri Department of Health and Senior Services, Section for Environmental Public Health, *Guidelines for Cleaning up Former Methamphetamine Labs, at* http://www.dhss.state.mo.us/ResourceMaterial/meth.pdf (last visited September 27, 2004).

North Dakota Dep't of Health, Div. of Waste Management, *Best Management Practices for Cleanups at Methamphetamine Labs, at* http://www.health.state.nd.us/ndhd/environ/wm/pdf/mo_drugs.pdf (last visited April 16, 2004).

Oklahoma Dep't of Environmental Quality, *Guidelines for Cleaning Up Former Methamphetamine Labs, at* http://www.deq.state.ok.us/LPDnew/MethLabs/meth.htm (last visited September 27, 2004).

Wisconsin Div. of Public Health, Bureau of Environmental Health, *Cleaning Up Hazardous Chemicals at Methamphetamine Laboratories, at* http://www.dhfs.state.wi.us/eh/ChemFS/fs/MethClnUp.htm (last visited September 27, 2004).

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100.

# DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## INITIAL ACTIONS FOR HANDLING CONTAMINATED PROPERTIES

A. Initial Reporting of Site to Appropriate Agency

B. Requirements Related to Warning and Notice to Property Owner

C. Procedure to Deem Property Unfit for Use

D. Preliminary Site Assessment

E. Agency Required to Maintain List of Contaminated Properties

F. Agency Required to Maintain List of Certified Contractors

G. City or County Options

## CERTIFIED CONTRACTOR INFORMATION

H. Use of State Certified Contractor

I. Training Provider Certification

J. Supervisor and Employee Training/Certification

K. Contractor Certification/Licensing

L. Contractor Registration

M. Contractor Work Plan

N. Contractor Performance Standards

O. Contractor Final Report

P. Contractor Penalties

Q. Civil Liability— Governmental Immunity

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## SAMPLING AND DECONTAMINATION

R. Sampling Procedures

S. Decontamination Standards/Decontamination Verification

T. Recording Decontamination

## OTHER

U. Buyer/Seller Disclosure and Transfer Requirements

V. Cleanup and Nuisance Ordinances

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# A. Initial Reporting of Site to Appropriate Agency

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. REV. STAT. ANN. § 12-1000 (West 2004).

**12-1000. Clandestine drug laboratories; notice; cleanup; residual contamination; civil penalty; immunity; restitution; violation; classification**

A. If a peace officer discovers a clandestine drug laboratory or arrests a person for having on any real property chemicals or equipment used in manufacturing methamphetamine, ecstasy or LSD or a derivative of methamphetamine, ecstasy or LSD, the peace officer:

1. At the time of the discovery or arrest, shall deliver a copy of the notice of removal pursuant to subsection B of this section to the owner of the real property if the owner is on the site at the time of delivery, the on-site manager if the manager is on the site at the time of delivery or the on-site drop box if available. In the case of a tenant-owned unit in a space rental mobile home or recreational vehicle park, the officer shall deliver a copy of the notice of removal to the occupant of the unit if the occupant is on site at the time of delivery and to the on-site park landlord if the park landlord is on site at the time of delivery.

2. Within two business days after the discovery or arrest, shall send the notice of removal by certified mail to the owner of the real property and the owner's on-site manager or, in the case of a space rental mobile home or recreational vehicle park, to the owner of the mobile home or recreational vehicle, if applicable, and to the park landlord. These persons are deemed to receive the notice of removal five days after the notice is mailed. The notice shall be sent to the following:

(a) The owner's address on file with the county assessor. The county shall waive any fee or charge for the owner's address information.

(b) The county health department.

(c) The appropriate local fire department.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### UTAH CODE ANN. § 19-6-903 (2004).

**19-6-903. Law enforcement reporting and records -- Removal from list.**

(1) (a) When any state or local law enforcement agency in the course of its official duties observes any paraphernalia of a clandestine drug laboratory operation, including chemicals or equipment used in the manufacture of unlawful drugs, the agency shall report the location where the items were observed to the local health department.

(b) (i) The law enforcement officer shall make the report under Subsection (1)(a) at the location where the observation occurred, if making the report at that time will not compromise an ongoing investigation.

(ii) If the report cannot be made at the location, the report shall be made as soon afterward as is practical.

(c) The report under Subsection (1)(a) shall include:

(i) the date of the observation;

(ii) the name of the reporting agency and the case number of the case that involves the location of the observation;

(iii) the contact information of the officer involved, including name and telephone number;

(iv) the address of the location and descriptions of the property that may be contaminated; and

(v) a brief description of the evidence at the location that led to the belief the property at the location may be contaminated.

(2) The law enforcement agency shall forward to the local health department copies of the reports made under Subsection (1).

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. REV. CODE ANN. § 64.44.020 (West 2004).

**RCW 64.44.020**
**Reporting -- Warning -- Notice -- Duties of local health officer.**

Whenever a law enforcement agency becomes aware that property has been contaminated by hazardous chemicals, that agency shall report the contamination to the local health officer. The local health officer shall post a written warning on the premises within one working day of notification of the contamination and shall inspect the property within fourteen days after receiving the notice of contamination. The warning shall inform the potential occupants that hazardous chemicals may exist on, or have been removed from, the premises and that entry is unsafe. If a property owner believes that a tenant has contaminated property that was being leased or rented, and the property is vacated or abandoned, then the property owner shall contact the local health officer about the possible contamination. Local health officers or boards may charge property owners reasonable fees for inspections of suspected contaminated property requested by property owners.

A local health officer may enter, inspect, and survey at reasonable times any properties for which there are reasonable grounds to believe that the property has become contaminated. If the property is contaminated, the local health officer shall post a written notice declaring that the officer intends to issue an order prohibiting use of the property as long as the property is contaminated.

Local health officers must report all cases of contaminated property to the state department of health. The department may make the list of contaminated properties available to health associations, landlord and realtor organizations, prosecutors, and other interested groups. The department shall promptly update the list of contaminated properties to remove those which have been decontaminated according to provisions of this chapter.

The local health officer may determine when the services of an authorized contractor are necessary.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# B. Requirements Related to Warning and Notice to Property Owner

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES**

## OR. ADMIN. R. § 333-040-0050 (2004).

**333-040-0050**

**Determination of Unfitness for Use**

(1) The determination that a property is unfit for use applies to any property that is known to have been used as an illegal drug manufacturing site, or for which there are reasonable grounds to believe that the property has been used as an illegal drug manufacturing site.

(2) Any owner of a property that was an illegal drug manufacturing site prior to August 3, 1989 may obtain a Certificate of Fitness by following all the procedures and meeting all the criteria of these rules.

(3)An agency determining property unfit for use shall proceed as follows:

(a) Notify the owner or agent of the affected property by personal service or by certified mail sent within 3 working days of the determination. Proof of such mailing shall be considered service. Proof of actual delivery is not required. Where the owner of record or the title or certificate holder is not listed in public records or cannot be reasonably notified, service of notice on the registered agent or other designated agent is sufficient;

(b) Mail a copy of the notice to the owner/agent as required in subsection (3)(a) of this rule to the Division. The Division shall notify the State Building Codes Division, the Department of Motor Vehicles, the State Marine Board and/or other affected agencies; and

(c) Post a standard warning notice provided by the Division at all entrances to the contaminated property at the time of the determination. Such notice(s) shall be displayed continuously until a Certificate of Fitness has been issued by the Division.

(4) The notice required in subsection (3)(a) of this rule shall include all of the specific information in the sample notice available from the Division, but need not be identical in form. This notice shall also include a statement that the owner may obtain a hearing by making a written request to the agency making the determination within 30 days.

Stat. Auth.: ORS 453.864

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### UTAH CODE ANN. § 19-6-905 (2004).

**19-6-905. Notification of property owner -- Notification of municipality or county.**

(1) (a) If the local health department determines a property is contaminated, it shall notify the owner of record that the property has been placed on the contamination list and shall provide to the owner information regarding remediation options and the requirements necessary to clean up the property, obtain certification that the property is decontaminated, and remove the property from the contamination list.

(b) The notification shall include a deadline for the owner to provide to the local health department information on how the owner plans to address the contamination.

(c) This part does not require that decontamination be conducted by a certified decontamination specialist. However, upon completion of the decontamination, the property must be determined to be decontaminated in accordance with Subsection **19-6-903**(4)(c) in order to be removed from the contamination list.

(2) If the local health department does not receive a response from the owner of record within the time period specified in the notice, or the owner of record advises the local health department that the owner does not intend to take action or that the reported property will be abandoned, the local health department shall notify the municipality in which the reported property is located, or the county, if the location is in an unincorporated area, of the owner of record's response or lack of response.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# C. Procedure to Deem Property Unfit for Use

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.876 (2003).

**453.876 Determination that property is not fit for use; appeal; notice to local residents.** (1) The Director of Human Services or a designee thereof, the State Fire Marshal or a designee thereof or any law enforcement agency may determine that property is not fit for use pursuant to ORS 105.555, 431.175 and 453.855 to 453.912 and applicable rules adopted by the Department of Human Services and may make that determination on site. The determination is effective immediately and renders the property not fit for use.

(2) The owner may appeal the determination, to the agency that made the determination, within 30 working days after the determination, pursuant to rules of the agency, or to circuit court.

(3) The appeal to the agency is not a contested case under ORS chapter 183. The question on appeal is limited to whether the site is an illegal drug manufacturing site.

(4) If a determination that property is not fit for use is made under subsection (1) of this section, a local government or the state may provide notice that the real property has been determined to be an illegal drug manufacturing site and not fit for use to:

(a) A person in each residence located within 300 feet of the real property if the real property is located within an urban growth boundary; or

(b) A person in each residence located within one quarter mile of the real property if the real property is not located within an urban growth boundary.

(5) The notice described in subsection (4) of this section shall be in writing and shall include:

(a) The address of the real property that is determined to be not fit for use;

(b) A statement that the determination is subject to appeal and that the real property may be determined to be fit for use if the appeal is successful or if the real property is certified as decontaminated;

(c) The telephone number of the office of the Department of Human Services that is responsible for overseeing the decontamination of illegal drug manufacturing sites; and

(d) The website for the Department of Human Services office responsible for overseeing the decontamination of illegal drug manufacturing sites that contains information on the dangers associated with real property that has been used as an illegal drug manufacturing site. [1989 c.915 §9; 1999 c.861 §2; 2003 c.559 §1]

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. REV. CODE ANN. § 64.44.030 (West 2004).

**RCW 64.44.030**
**Unfit for use -- Order -- Notice -- Hearing.**

If after the inspection of the property, the local health officer finds that it is contaminated, then the property shall be found unfit for use. The local health officer shall cause to be served an order prohibiting use either personally or by certified mail, with return receipt requested, upon all occupants and persons having any interest therein as shown upon the records of the auditor's office of the county in which such property is located. The local health officer shall also post the order prohibiting use in a conspicuous place on the property. If the whereabouts of such persons is unknown and the same cannot be ascertained by the local health officer in the exercise of reasonable diligence, and the health officer makes an affidavit to that effect, then the serving of the order upon such persons may be made either by personal service or by mailing a copy of the order by certified mail, postage prepaid, return receipt requested, to each person at the address appearing on the last equalized tax assessment roll of the county where the property is located or at the address known to the county assessor, and the order shall be posted conspicuously at the residence. A copy of the order shall also be mailed, addressed to each person or party having a recorded right, title, estate, lien, or interest in the property. The order shall contain a notice that a hearing before the local health board or officer shall be held upon the request of a person required to be notified of the order under this section. The request for a hearing must be made within ten days of serving the order. The hearing shall then be held within not less than twenty days nor more than thirty days after the serving of the order. The officer shall prohibit use as long as the property is found to be contaminated. A copy of the order shall also be filed with the auditor of the county in which the property is located, and such filing of the complaint or order shall have the same force and effect as other lis pendens notices provided by law. In any hearing concerning whether property is fit for use, the property owner has the burden of showing that the property is decontaminated or fit for use. The owner or any person having an interest in the property may file an appeal on any order issued by the local health board or officer within thirty days from the date of service of the order with the appeals commission established pursuant to RCW 35.80.030. All proceedings before the appeals commission, including any subsequent appeals to superior court, shall be governed by the procedures established in chapter 35.80 RCW.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# D. Preliminary Site Assessment

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## ARIZ. ADMIN. CODE R.4-30—305(A) (2004).

**R4-30-305. Drug Laboratory Site Remediation Best Standards and Practices**

A. Preliminary procedures.

1. The nature and extent of damage and contamination of the residually contaminated portion of the real property shall be determined.
2. The on-site supervisor shall request copies of any law enforcement, state agency, or other report regarding the nature and extent of illegal drug activity, evidence of what materials were removed from the real property and the location from which they were removed.
3. The on-site supervisor shall:
   a. Evaluate all information obtained regarding the nature and extent of damage and contamination;
   b. Develop procedures to safely enter the residually contaminated portion of the real property in order to conduct a visual assessment;
   c. Wear the appropriate personal protective equipment for the condition(s) assessed;
   d. Visually inspect the residually contaminated portion of the real property; and
   e. Be assisted by at least one on-site worker during the initial entry into the residually contaminated portion of the real property.
4. The on-site supervisor shall conduct and document appropriate testing for corrosive, flammable, combustible, and toxic atmospheres during the initial entry in the residually contaminated portion of the real property, such as a LEL/O2 meter, pH paper, PID, FID, or equivalent equipment.
5. If there was a fire or explosion in the residually contaminated portion of the real property which appears to have compromised its structural integrity, the drug laboratory site remediation firm shall obtain a structural assessment of the residually contaminated portion of the real property.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## WASH. ADMIN. CODE § 246-205-530 (2004).

**WAC 246-205-530 Inspecting property.** Within fourteen days after a law enforcement agency or property owner notifies the local health officer of potential property contamination, the local health officer shall inspect the property.

(1) To enable the local health officer to determine contamination, the property inspection shall include, but not be limited to, an acquisition of data such as evidence of:

(a) Hazardous chemical use or storage on site;

(b) Chemical stains;

(c) Release or spillage of hazardous chemicals on the property; or

(d) Glassware or other paraphernalia associated with the manufacture of illegal drugs on site.

(2) As part of the property's inspection, the local health officer may request copies of any law enforcement reports, forensic chemist reports, and any department of ecology hazardous material transportation manifests needed to evaluate:

(a) The length of time the property was used as an illegal drug manufacturing or storage site;

(b) The size of the site actually used for the manufacture or storage of illegal drugs;

(c) What chemical process was involved in the manufacture of illegal drugs;

(d) What chemicals were removed from the scene; and

(e) The location of the illegal drug manufacturing or storage site in relation to the habitable areas of the property.

(3) The local health officer may coordinate the property's inspection with other appropriate agencies. At the request of the local health officer, the Washington state department of ecology may conduct an environmental assessment and may sample the property's ground water, surface water, septic tank water, soil, and other media as necessary to enable the local health officer to evaluate the long-term public health threats.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# E. Agency Required to Maintain List of Contaminated Properties

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.879 (2003).

**453.879 Director of the Department of Consumer and Business Services to be notified of determination.** When the Director of Human Services or a designee thereof, the State Fire Marshal or designee thereof or any law enforcement agency makes a determination that property subject to ORS 105.555, 431.175 and 453.855 to 453.912 is not fit for use, the Director of Human Services or designee thereof shall notify the Director of the Department of Consumer and Business Services of the determination. The Director of the Department of Consumer and Business Services shall list the property as not fit for use until the Director of the Department of Consumer and Business Services is notified that the property has been certified by the Department of Human Services pursuant to ORS 453.885, or the initial determination is reversed on appeal, or the property is destroyed. Upon receipt of the certificate, the Director of the Department of Consumer and Business Services shall cause the property to be removed from the list described in this section. [1989 c.915 §10; 2003 c.14 §279]

### OR. ADMIN. R. § 918-010-0015 (2004).

**918-010-0015**

**Registry of Property "Unfit For Use"**

(1) As required by ORS 453.879, there is created within the Building Codes Division, a registry of property "Unfit For Use".

(2) The registry shall list property determined as "unfit for use" under ORS 453.876 and under the rules of the Health Division.

(3) Property declared "unfit for use" shall be listed in the registry only when the Health Division advises the division that action has been taken to declare the property as not fit for use. The listing will show the information provided by the Health Division.

(4) Property listed in the registry will be removed from the registry when:

(a) The division receives a certificate of fitness from the Health Division;

(b) The division is formally advised by a certified copy of a final court judgment that the initial "unfit for use determination" was reversed on appeal under ORS 453.876, or if the reversal was by administrative action, a certified copy of the final division order; or

(c) The division is provided with confirmed evidence, including proof or an affirmation that all lawful requirements were followed, that the contaminated property has been destroyed.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### UTAH CODE ANN. § 19-6-903 (2004).

**19-6-903. Law enforcement reporting and records -- Removal from list.**

(1) (a) When any state or local law enforcement agency in the course of its official duties observes any paraphernalia of a clandestine drug laboratory operation, including chemicals or equipment used in the manufacture of unlawful drugs, the agency shall report the location where the items were observed to the local health department.

(b) (i) The law enforcement officer shall make the report under Subsection (1)(a) at the location where the observation occurred, if making the report at that time will not compromise an ongoing investigation.

(ii) If the report cannot be made at the location, the report shall be made as soon afterward as is practical.

(c) The report under Subsection (1)(a) shall include:

(i) the date of the observation;

(ii) the name of the reporting agency and the case number of the case that involves the location of the observation;

(iii) the contact information of the officer involved, including name and telephone number;

(iv) the address of the location and descriptions of the property that may be contaminated; and

(v) a brief description of the evidence at the location that led to the belief the property at the location may be contaminated.

(2) The law enforcement agency shall forward to the local health department copies of the reports made under Subsection (1).

(3) (a) Upon receipt of a complaint or a report from law enforcement regarding possibly contaminated property, the local health officer or his designee shall determine if reasonable evidence exists that the property is contaminated.

(b) The local health department shall place property considered to be contaminated on a contamination list.

(4) The local health departments shall maintain searchable records of the properties on their contamination lists and shall:

(a) make the records reasonably available to the public;

(b) provide written notification to persons requesting access to the records that the records are only advisory in determining if specific property has been contaminated by clandestine drug lab activity; and

(c) remove the contaminated property from the list when the following conditions have been met:

(i) the local health department has monitored the decontamination process and, after documenting that the test results meet decontamination standards, has authorized the removal of or purging of the contamination information from the department's records; or

(ii) a certified decontamination specialist submits a report to the local health department stating that the property is decontaminated.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# F. Agency Required to Maintain List of Certified Contractors

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.897 (2003).

**453.897 Lists of licensed contractors to be made available.** The Department of Human Services shall provide lists of the names of contractors licensed under ORS 105.555, 431.175 and 453.855 to 453.912 to the Director of the Department of Consumer and Business Services who shall distribute the lists to local building code enforcement agencies. The local agencies shall make the list available on request and shall supply a copy to any property owner whose property is determined to be not fit for use under ORS 105.555, 431.175 and 453.855 to 453.912. [1989 c.915 §15]

### OR. ADMIN. R. § 333-040-0120 (2004).

**333-040-0120**

**Contractor Listing**

The Division shall maintain a complete listing of Drug Laboratory Decontamination Contractors and shall provide copies of the list as follows:

(1) To the Director of the Department of Consumer and Business Services who shall supply the list and updates to local building code enforcement agencies;

(2) To the Administrator of each county health department in the state;

(3) Upon request, to any property owner, prospective buyer, licensee or other interested person.

### WASH. ADMIN. CODE § 246-205-131 (2004).

**WAC 246-205-131 Certified contractor list.** (1) The department shall maintain a list of authorized illegal drug manufacturing or storage site decontamination contractors.

(2) The department's authorized contractor list shall be made available to local health officials and other appropriate agencies semiannually, and to the public upon request.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# G. City or County Options

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.909 (2003).

**453.909 Authority of counties and cities.** Counties and cities by ordinance may prohibit use or occupancy of or provide for regulation of any property so long as such prohibition or regulation is consistent with ORS 105.555, 431.175 and 453.855 to 453.912 and rules of the Department of Human Services. [1989 c.915 §20; 1999 c.861 §6]

### WASH. REV. CODE ANN. § 64.44.040 (West 2004).

**RCW 64.44.040**
**City or county options.**

The city or county in which the contaminated property is located may take action to condemn or demolish property or to require the property be vacated or the contents removed from the property. The city or county may use an authorized contractor if property is demolished, decontaminated, or removed under this section. No city or county may condemn or demolish property pursuant to this section until all procedures granting the right of notice and the opportunity to appeal in RCW 64.44.030 have been exhausted.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# H. Use of State Certified Contractor

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.885 (2003).

**453.885 Decontamination of property; certification process.** (1) The owner of property determined to be not fit for use under ORS 105.555, 431.175 and 453.855 to 453.912 who desires to have the property certified as fit for use may use the services of a contractor licensed by the Department of Human Services to decontaminate the property or, upon approval by the department, the owner, or an agent of the owner, may perform the decontamination work. The contractor, in coordination with the owner or agent of the owner, shall prepare and submit a written work plan for decontamination to the department. If the work plan is approved and the decontamination work is completed according to the plan and is properly documented, the department shall certify the property as having been decontaminated in compliance with rules of the department. Upon the completion of the work plan, the department shall require the licensed contractor's affidavit of compliance with the approved work plan.

(2) The property owner shall notify the Director of the Department of Consumer and Business Services of the certification. No person who is not licensed by the Department of Human Services under ORS 105.555, 431.175 and 453.855 to 453.912 shall advertise to undertake or perform the work necessary to decontaminate property determined to be not fit for use under ORS 105.555, 431.175 and 453.855 to 453.912.

(3) Upon receipt of the certificate and a request by the property owner to remove the property from the list, the Director of the Department of Consumer and Business Services shall cause the property to be removed from the list. [1989 c.915 §11; 1999 c.861 §3]

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. REV. CODE ANN. § 64.44.050 (West 2004).

**RCW 64.44.050**
**Decontamination by owner -- Requirements.**

An owner of contaminated property who desires to have the property decontaminated shall use the services of an authorized contractor unless otherwise authorized by the local health officer. The contractor shall prepare and submit a written work plan for decontamination to the local health officer. The local health officer may charge a reasonable fee for review of the work plan. If the work plan is approved and the decontamination is completed and the property is retested according to the plan and properly documented, then the health officer shall allow reuse of the property. A release for reuse document shall be recorded in the real property records indicating the property has been decontaminated in accordance with rules of the state department of health.

### WASH. ADMIN. CODE § 246-205-570 (2004).

**WAC 246-205-570 Decontamination.** (1) An owner of contaminated property who desires to reduce the contamination shall use the services of an authorized contractor unless otherwise authorized by the local health officer.

(2) The local health officer shall provide the property owner with a list of authorized contractors upon request.

(3) When an authorized contractor is required for decontamination, the property owner shall have a written work plan approved by the local health officer before starting decontamination.

(4) When an authorized contractor is required for decontamination, the contractor shall prepare the work plan in accordance with this chapter and chapter 64.44 RCW. When the local health officer determines the services of an authorized contractor are not necessary, the local health officer shall take appropriate measures to ensure the property is decontaminated consistent with the purposes of chapter 64.44 RCW.

(5) The property owner or the contractor shall decontaminate the property according to the approved work plan and to meet the decontamination standards described in WAC 246-205-541.

(6) The property owner shall be responsible for:

(a) The costs of any property testing which may be required to demonstrate the presence or absence of hazardous chemicals;

(b) The costs of the property's decontamination and disposal expenses, as well as costs incurred by the local health officer resulting from the enforcement of this chapter;

(c) Keeping records documenting decontamination procedures and submitting notarized copies of all records to the local health officer; and

(d) Petitioning the local health officer to review the decontamination records and to declare the property decontaminated.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# I. Training Provider Certification

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE §§ 246-205-021, -051 (2004).

**WAC 246-205-021 Training provider certification.** (1) Persons wanting to become an illegal drug lab decontamination training provider must obtain department approval of instructors and courses. The types of drug lab decontamination courses that may be approved by the department are:

(a) Basic worker;

(b) Basic supervisor; and

(c) Refresher worker and supervisor.

(2) To obtain approval of instructors, the applicant must demonstrate that the person has the breadth of knowledge and experience necessary to properly train workers and supervisors.

(3) To obtain approval of course work, the applicant must demonstrate the:

(a) Adequacy and accuracy of content; and

(b) Adequacy of training techniques.

(4) Applicants for training provider certification shall:

(a) Submit a completed training provider application as specified under subsection (5) of this section;

(b) Submit the required fee as specified under WAC 246-205-990; and

(c) Ensure the department receives the application sixty or more days before the requested approval date.

(5) A training provider application includes, but is not limited to:

(a) A completed training provider application form provided by the department;

(b) A list of all personnel involved in course presentation and a description of their qualifications;

(c) A detailed description of course content and the amount of time allotted to each major topic;

(d) A description of teaching methods;

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

(e) A list of questions for development of an examination; and

(f) Copies of all materials proposed for use, when requested from the department.

(6) Training provider certification is valid for two years from the date of issuance.

(7) Training provider certification may be terminated if the training provider fails to:

(a) Maintain the course content and quality as approved by the department; and

(b) Make changes to a course as required by the department.

**WAC 246-205-051 Certified training provider responsibilities.** (1) Prior to any training, the training provider shall:

(a) Notify the department in writing thirty or more days before training is scheduled to begin. The notification shall include the date, time, and address of the location where training will be conducted;

(b) Ensure that the size of the class is appropriate for learning the course content;

(c) Incorporate into training any required subject matter developed by the department;

(d) Obtain department approval in advance of any changes to the training; and

(e) Maintain the course content and quality as approved by the department.

(2) When requested by the department, the training provider shall confirm successful completion of CDL worker or supervisor training courses by applicants seeking CDL worker or supervisor certification.

(3) At the department's request, the training provider shall allow a department representative to attend a training course as an observer to verify that the training provider conducts the training in accordance with the training approved by the department.

(4) Training providers conducting training outside the state of Washington shall:

(a) Reimburse the department at current state of Washington per diem and travel allowance rates for travel expenses associated with department observance of the training courses; and

(b) Submit reimbursement to the department within thirty days of receipt of the billing notice.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# J. Supervisor and Employee Training/Certification

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. ADMIN. CODE R.4-30-271, -272 (2004).

**R4-30-271. On-site Supervisor Certification and Renewal**

A. An applicant for on-site supervisor certification shall submit an original and one copy of a completed application package that contains the following:
   1. Name, residence address, mailing address if different from residence address, and telephone number;
   2. Date of birth and social security number of the applicant;
   3. Citizenship or legal residence;
   4. State or jurisdiction in which any other professional or occupational certification, registration, or license is held by the applicant, type of certification, registration, or license, number, and year granted;
   5. The name of the state or jurisdiction, the type of professional or occupational certification, registration, or license the applicant is seeking, and the status of any professional or occupational certification, registration, or license application pending in any state or jurisdiction;
   6. A detailed explanatory statement, regarding:
      a. Refusal of professional or occupational certification, registration, or license by any state or jurisdiction;
      b. Any pending disciplinary action in any state or jurisdiction on any professional or occupational certification, registration, or license held by the applicant;
      c. Any alias or other name used by the applicant;
      d. Any conviction for a felony or misdemeanor, other than a minor traffic violation; and
      e. Any disciplinary action taken by any state or jurisdiction on any professional or occupational registration, certification, or license held by the applicant in any state or jurisdiction.
   7. Certification that the information provided to the Board is accurate, true, and complete;
   8. A copy of a current 40-hour HAZWOPER training certificate or a copy of a current 8-hour HAZWOPER refresher certificate and a copy of a 40-hour HAZWOPER training certificate;
   9. Documentation of 12 months or more of on-site experience in hazardous chemical decontamination projects and a copy of a HAZWOPER certificate that shows the applicant held valid HAZWOPER certification during the 12 months of experience;
   10. Documentation of current AHERA contractor or supervisor certification or a copy of a current AHERA refresher certificate and a copy of an AHERA contractor or supervisor training certificate;
   11. Documentation of successful completion of a lead training course that meets the requirements of 29 CFR 1926.62(l), effective January 8, 1998, 63 FR 1296, the provisions of which are incorporated by reference and on file with the Secretary of State, copies of which are available at the office of the Board of Technical Registration;

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

12. A signed release authorizing the Board to investigate the applicant's education, experience, and moral character and repute; and
13. The applicable fee.

B. Beginning September 30, 2003, an applicant for renewal of on-site supervisor certification shall submit an application package that contains:
1. A completed renewal application form provided by the Board, signed and dated by the registrant that provides the information contained in subsections (A)(1), (2), (6), and (7);
2. A copy of the registrant's current 8-hour HAZWOPER refresher certificate;
3. A copy of the registrant's current AHERA refresher certificate;
4. For the first annual renewal, documentation of successful completion of an 8-hour training course approved by the Board that encompasses the following:
   a. Clandestine Drug Laboratory Site Remediation Best Standards and Practices contained in R4-30-305;
   b. Chemical and physical hazards of a clandestine drug laboratory;
   c. Typical manufacturing methods for methamphetamine, LSD, and ecstasy;
   d. Typical flammable, combustible, corrosive, and reactive materials used in a clandestine drug laboratory;
   e. Potential sharps and biohazards at a clandestine drug laboratory;
   f. Proper handling and disposal of wastes from the remediation of a clandestine drug laboratory; and
   g. Other potential hazards or dangers that can be associated with a clandestine drug laboratory;
5. For the first annual renewal, documentation of successful completion of an 8-hour training course approved by the Board that encompasses the following:
   a. Hazardous and precautionary measures for initial entry into a clandestine drug laboratory site;
   b. Assessment of residual contamination;
   c. Preparation of the work plans for remediation of a clandestine drug laboratory;
   d. Assessment of the structural stability for safe entry into a clandestine drug laboratory site;
   e. Characterizing waste from the remediation of a clandestine drug laboratory; and
   f. Preparing final reports on the remediation of the clandestine drug laboratory;
6. For the second and all subsequent annual renewals, documentation of successful completion of a 2-hour refresher training course approved by the Board that encompasses the following:
   a. Clandestine Drug Laboratory Site Remediation Best Standards and Practices contained in R4-30-305;
   b. Hazardous and precautionary measures for initial entry into a clandestine drug laboratory site;
   c. Preparation of the work plan for remediation of a clandestine drug laboratory;
   d. Assessment of the structural stability for safe entry into a clandestine drug laboratory site;
   e. Characterizing waste from the remediation of a clandestine drug laboratory; and
   f. Preparing the final report on the remediation of a clandestine drug laboratory;
7. The applicable fee.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

C. The Board staff shall review all applications and, if necessary, refer completed applications to the Environmental Remediation Rules and Standards Committee for evaluation. If the application is complete and in the proper form, and the Board staff or committee is satisfied that all statements on the application are true and that the applicant is eligible in all other aspects to be certified, the Board staff or committee shall recommend that the Board certify the applicant. If for any reason the Board staff or committee is not satisfied that all of the statements on the application are true, the Board staff shall make a further investigation of the applicant. The Board staff or committee shall submit recommendations to the Board for approval. The Board may also require a applicant to submit additional oral or written information if the applicant has not furnished satisfactory evidence of qualifications for certification.

**R4-30-272. On-site Worker Certification and Renewal**

A. An applicant for on-site worker certification shall submit an original and one copy of a completed application package that contains the following:
   1. Name, residence address, mailing address if different from residence address, and telephone number;
   2. Date of birth and social security number of the applicant;
   3. Citizenship or legal residence;
   4. State or jurisdiction in which any professional or occupational certification, registration, or license is held by the applicant, type of certification, registration, or license, number, and year granted;
   5. Name of the state or jurisdiction, the type of professional or occupational certification, registration, or license the applicant is seeking, and the status of any professional or occupational application pending in any state or jurisdiction;
   6. A detailed explanatory statement regarding:
      a. Any refusal of professional or occupational certification, registration, or license by any state or jurisdiction;
      b. Any pending disciplinary action in any state or jurisdiction on any professional or occupational certification, registration, or license held by the applicant;
      c. Any alias or other name used by the applicant;
      d. Any conviction for a felony or misdemeanor, other than a minor traffic violation; and
      e. Any disciplinary action taken by any state or jurisdiction on any professional or occupational certification, registration, or license held by the applicant in any state or jurisdiction;
   7. Certification that the information provided to the Board is accurate, true, and complete;
   8. Copy of a current 40-hour HAZWOPER training certificate or copy of a current 8-hour HAZWOPER refresher certificate and a copy of a 40-hour HAZWOPER training certificate;
   9. A signed release authorizing the Board to investigate the applicant's education, experience, and moral character and repute; and
   10. The applicable fee.

B. Effective September 30, 2003, an applicant for renewal of on-site worker certification shall submit an application package that contains:

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

**DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES**

1. A completed renewal application form provided by the Board, signed and dated by the applicant that provides the information contained in subsections (A)(1), (2), (6) and (7);
2. A copy of the applicant's current 8-hour HAZWOPER refresher certificate;
3. For the first annual renewal, documentation of successful completion of an 8-hour training course approved by the Board that encompasses the following:
   a. Clandestine Drug Laboratory Site Remediation Best Standards and Practices contained in R4-30-305;
   b. Chemical and physical hazards of a clandestine drug laboratory;
   c. Typical manufacturing methods for methamphetamine, LSD, and ecstasy;
   d. Typical flammable, combustible, corrosive, and reactive materials used in a clandestine drug laboratory;
   e. Potential sharps and biohazards at a clandestine drug laboratory;
   f. Proper handling and disposal of wastes from the remediation of a clandestine drug laboratory; and
   g. Other potential hazards or dangers that can be associated with a clandestine drug laboratory;
4. The applicable fee.

C. The Board staff shall review all applications and, if necessary, refer completed applications to the Environmental Remediation Rules and Standards Committee for evaluation. If the application is complete and in the proper form, and the Board staff or committee is satisfied that all statements on the application are true and the applicant is eligible in all other respects to be certified, the Board staff or committee shall recommend that the Board certify the applicant. If for any reason the Board staff or committee is not satisfied that all of the statements on the application are true, the Board staff shall make a further investigation of the applicant. The Board staff or committee shall submit recommendations to the Board for approval. The Board may also require an applicant to submit additional oral or written information if the applicant has not furnished satisfactory evidence of qualifications for certification.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE § 246-205-031 (2004).

**WAC 246-205-031 Basic training course content.** Department approved basic worker and supervisor training courses shall provide at a minimum:

(1) Information on state and federal laws, rules, and regulations applicable to illegal drug manufacturing or storage sites including, but not limited to, Contaminated properties, chapter 64.44 RCW; Precursor drugs, chapter 69.43 RCW; Uniform Controlled Substances Act, chapter 69.50 RCW; Washington Industrial Safety and Health Act, chapter 49.17 RCW; the Federal Occupational Health and Safety Act, 29 U.S.C. 651 et seq.; and this chapter.

(2) Chemical terminology, classifications, and properties related to illegal drug manufacturing.

(3) Illegal drug laboratory characteristics.

(4) First aid.

(5) Adverse health effects of exposure related to illegal drug manufacturing including, but not limited to:
(a) Toxicology; and
(b) Symptomology.
(6) Incompatibility of chemicals related to decontamination.
(7) Techniques and equipment used for decontamination of property.
(8) Handling unknown substances.
(9) State and federal requirements for dealing with hazardous materials including, but not limited to, chapter 173-303 WAC related to:
(a) Disposal;
(b) Transportation;
(c) Storage; and
(d) Reporting.
(10) Training for supervisors must also include, but not be limited to:
(a) Obtaining necessary information for making site assessments;
(b) Initial site assessment;
(c) Initial site sampling;
(d) Work plan development;
(e) Final site sampling;
(f) Report completion; and
(g) Penalties and liabilities.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# K. Contractor Certification/Licensing

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.888 (2003).

**453.888 License required to perform decontamination; procedure; grounds for denial, revocation or suspension of license; civil penalty.** (1) The Department of Human Services by rule shall establish performance standards for contractors under ORS 105.555, 431.175 and 453.855 to 453.912.

(2) The department shall train and test, or may approve courses to train and test, contractors' personnel on the essential elements in assessing premises used as an illegal drug manufacturing site to determine hazard reduction measures needed, techniques for adequately reducing contaminants, use of personal protective equipment and relevant federal regulations and state rules.

(3) Upon the contractor's supervisory personnel's successful completion of the training and testing and the contractor having complied with the rules of the department and having paid the required fee, the contractor shall be licensed. Licenses are renewable biennially, as determined by rule of the department, upon supervisory personnel's successful completion of any required refresher course.

(4) The department may deny, suspend or revoke the license of any contractor pursuant to ORS chapter 183 for:

(a) Failing to:

(A) Perform decontamination work under the supervision of trained personnel;

(B) File a work plan;

(C) Perform work pursuant to the plan;

(D) Pay a civil penalty imposed under ORS 105.555, 431.175 and 453.855 to 453.912; or

(E) Perform work that meets the requirements of ORS 453.903.

(b) Committing fraud or misrepresentation in:

(A) Applying for a license;

(B) Seeking approval of a work plan; or

(C) Documenting completion of the work to the department.

(5) The department may impose a civil penalty not to exceed $500, in addition to or in lieu of license denial, suspension or revocation, pursuant to ORS chapter 183. [1989 c.915 §13; 1991 c.67 §126]

### OR. ADMIN. R. § 333-040-0110 (2004).

**333-040-0110**

**Qualifications, Training and Licensing of Contractors and Employees**

(1) No person or entity shall advertise to undertake, or perform the work necessary to assess or decontaminate properties found to be unfit for use, without first complying with these rules and securing a license to do so pursuant to ORS 453.885(2), 453.888 and Oregon Laws 1999, chapter 861, section 3, except as set forth in section (2) of this rule or in OAR 333-040-0065(2) and (3).

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

(2) Before applying for a decontamination contractor license, a contractor must be registered, bonded and insured as a general contractor with the Construction Contractor's Board. Companies and persons providing only sample collection, transportation and testing services for drug laboratory decontamination contractors are not required to be licensed pursuant to these rules; however, a contractor shall supervise anyone providing sample collection as set forth in OAR 333-040-0130(1), and anyone providing sample collection services shall comply with the hazardous materials training required in section (5) of this rule and the qualification and training requirements of OAR 333-040-0135. Laboratories providing sample analysis shall comply with OAR 333-040-0070(3)(a).

(3) The contractor shall provide documentation to the Division that its supervisory personnel seeking training and certification as a drug laboratory decontamination supervisor have successfully completed at least 40 hours of hazardous materials training satisfying the requirements of OAR 437-002-0100(18) and 29 CFR 1910.120(e). The contractor shall insure that only persons so qualifying are admitted for training, examination or on-site work as an illegal drug manufacturing site decontamination supervisor.

(4) Applicants shall demonstrate that all employees who will perform work on illegal drug manufacturing sites have completed a Division-sponsored specialized training course and have successfully passed the course examination with a score of seventy percent or greater.

(5) The contractor shall insure that its employees and agents who have on-site duties or who handle contaminated materials, chemicals or contaminated equipment, shall be trained as required by OAR 437-002-0100(18) and 29 CFR 1910.120(e) before engaging in assessment, testing or decontaminating illegal drug manufacturing sites. Refresher training as required by said rules and regulations shall be kept current.

(6) The contractor's supervisory employees performing on-site drug site decontamination activities shall successfully complete the initial training course required in section (4) of this rule and shall successfully complete refresher training specified by the Division every other year to renew their certification. The Division may also require more frequent training updates.

(7) The contractor's non-supervisory employees who have on-site exposure to properties found unfit for use shall receive specialized drug site decontamination training before having any on-site exposure, and must attend refresher training at least every other year to renew their certification. The contractor shall supply the Division with documentation of such training for each employee who enters an illegal drug manufacturing site. Training referred to in sections (6) and (7) of this rule is required in addition to the training required by State and Federal OSHA regulations referred to in section (5) of this rule.

(8) All contractors and all employees of any contractor shall carry identification provided by the Division attesting to their training credentials and level of training whenever performing duties at an illegal drug manufacturing site.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## WASH. REV. CODE ANN. § 64.44.060 (West 2004).

**RCW 64.44.060**
**Certification of contractors -- Denial, suspension, or revocation of certificate -- Duties of department of health -- Decontamination account.**

(1) A contractor may not perform decontamination, demolition, or disposal work unless issued a certificate by the state department of health. The department shall establish performance standards for contractors by rule in accordance with chapter 34.05 RCW, the administrative procedure act. The department shall train and test, or may approve courses to train and test, contractors and their employees on the essential elements in assessing property used as an illegal drug manufacturing or storage site to determine hazard reduction measures needed, techniques for adequately reducing contaminants, use of personal protective equipment, methods for proper decontamination, demolition, removal, and disposal of contaminated property, and relevant federal and state regulations. Upon successful completion of the training, the contractor or employee shall be certified.

(2) The department may require the successful completion of annual refresher courses provided or approved by the department for the continued certification of the contractor or employee.

(3) The department shall provide for reciprocal certification of any individual trained to engage in decontamination, demolition, or disposal work in another state when the prior training is shown to be substantially similar to the training required by the department. The department may require such individuals to take an examination or refresher course before certification.

(4) The department may deny, suspend, or revoke a certificate for failure to comply with the requirements of this chapter or any rule adopted pursuant to this chapter. A certificate may be denied, suspended, or revoked on any of the following grounds:

(a) Failing to perform decontamination, demolition, or disposal work under the supervision of trained personnel;

(b) Failing to file a work plan;

(c) Failing to perform work pursuant to the work plan;

(d) Failing to perform work that meets the requirements of the department;

(e) The certificate was obtained by error, misrepresentation, or fraud; or

(f) If the person has been certified pursuant to RCW 74.20A.320 by the department of social and health services as a person who is not in compliance with a support order or a residential or visitation order. If the person has continued to meet all other requirements

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the department's receipt of a release issued by the department of social and health services stating that the person is in compliance with the order.

(5) A contractor who violates any provision of this chapter may be assessed a fine not to exceed five hundred dollars for each violation.

(6) The department of health shall prescribe fees as provided for in RCW 43.70.250 for the issuance and renewal of certificates, the administration of examinations, and for the review of training courses.

(7) The decontamination account is hereby established in the state treasury. All fees collected under this chapter shall be deposited in this account. Moneys in the account may only be spent after appropriation for costs incurred by the department in the administration and enforcement of this chapter.

## WASH. ADMIN. CODE § 246-205-091 (2004).

**WAC 246-205-091 Contractor certification.** (1) A contractor may advertise, offer to undertake, or perform decontamination, demolition, or disposal work at an illegal drug manufacturing or storage site only after securing a certificate from the department.

(2) Applicants for department certification as an authorized contractor, shall submit to the department:

(a) Evidence of being licensed, bonded, and insured as a general contractor under the provisions of chapter 18.27 RCW;

(b) Evidence of department certification for each employee who will do work on an illegal drug manufacturing or storage site;

(c) Documentation that the contractor has at least one department certified supervisor and one department certified worker;

(d) A completed decontamination contractor application form; and

(e) A fee as prescribed in WAC 246-205-990.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# L. Contractor Registration

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. ADMIN. CODE R.4-30-270 (2004).

**R4-30-270. Drug Laboratory Site Remediation Firm Registration**

An applicant for drug laboratory site remediation firm registration shall submit an original and one copy of a completed application package that contains the following:

1. Name of business, business address, mailing address if different from business address, and business telephone number;
2. Description of the applicant's services offered to the public;
3. Name and certification number of each on-site supervisor who is authorized and responsible for the services being offered;
4. Legal status of business, such as corporation, partnership, sole proprietorship, or other status;
5. Name and address of the responsible individual in the firm to whom notices and correspondence from the Board should be mailed; and
6. Certification that the information provided to the Board is accurate, true, and complete;
7. Copy of a current license issued by the Registrar of Contractors, the scope of which permits the applicant to perform the activities required of drug laboratory site remediation firms certified pursuant to this Chapter;
8. The applicable fee.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# M. Contractor Work Plan

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### UTAH CODE ANN. § 19-6-904 (2004).

**19-6-904. Decontamination specialist reporting to local health departments.**

(1) A certified decontamination specialist is required to report to the local health department the location of any property that is the subject of decontamination work by that decontamination specialist. The report shall be submitted prior to commencement of the decontamination work.

(2) The report under Subsection (1) shall include:

(a) sufficient information to allow the local health department to investigate and verify the location of the property, including the address and description of the property; and

(b) a proposed work plan for decontaminating the property.

(3) Upon completion of the decontamination process, a report certifying that the property is decontaminated shall be submitted to the local health department within 30 days.

### WASH. REV. CODE ANN. § 64.44.050 (West 2004).

**RCW 64.44.050**
**Decontamination by owner -- Requirements.**

An owner of contaminated property who desires to have the property decontaminated shall use the services of an authorized contractor unless otherwise authorized by the local health officer. The contractor shall prepare and submit a written work plan for decontamination to the local health officer. The local health officer may charge a reasonable fee for review of the work plan. If the work plan is approved and the decontamination is completed and the property is retested according to the plan and properly documented, then the health officer shall allow reuse of the property. A release for reuse document shall be recorded in the real property records indicating the property has been decontaminated in accordance with rules of the state department of health.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# N. Contractor Performance Standards

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## WASH. REV. CODE ANN. § 64.44.060 (West 2004).

**RCW 64.44.060**
**Certification of contractors -- Denial, suspension, or revocation of certificate -- Duties of department of health -- Decontamination account.**

(1) A contractor may not perform decontamination, demolition, or disposal work unless issued a certificate by the state department of health. The department shall establish performance standards for contractors by rule in accordance with chapter 34.05 RCW, the administrative procedure act. The department shall train and test, or may approve courses to train and test, contractors and their employees on the essential elements in assessing property used as an illegal drug manufacturing or storage site to determine hazard reduction measures needed, techniques for adequately reducing contaminants, use of personal protective equipment, methods for proper decontamination, demolition, removal, and disposal of contaminated property, and relevant federal and state regulations. Upon successful completion of the training, the contractor or employee shall be certified.

(2) The department may require the successful completion of annual refresher courses provided or approved by the department for the continued certification of the contractor or employee.

(3) The department shall provide for reciprocal certification of any individual trained to engage in decontamination, demolition, or disposal work in another state when the prior training is shown to be substantially similar to the training required by the department. The department may require such individuals to take an examination or refresher course before certification.

(4) The department may deny, suspend, or revoke a certificate for failure to comply with the requirements of this chapter or any rule adopted pursuant to this chapter. A certificate may be denied, suspended, or revoked on any of the following grounds:

(a) Failing to perform decontamination, demolition, or disposal work under the supervision of trained personnel;

(b) Failing to file a work plan;

(c) Failing to perform work pursuant to the work plan;

(d) Failing to perform work that meets the requirements of the department;

(e) The certificate was obtained by error, misrepresentation, or fraud; or

(f) If the person has been certified pursuant to RCW 74.20A.320 by the department of

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

social and health services as a person who is not in compliance with a support order or a residential or visitation order. If the person has continued to meet all other requirements for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the department's receipt of a release issued by the department of social and health services stating that the person is in compliance with the order.

(5) A contractor who violates any provision of this chapter may be assessed a fine not to exceed five hundred dollars for each violation.

(6) The department of health shall prescribe fees as provided for in RCW 43.70.250 for the issuance and renewal of certificates, the administration of examinations, and for the review of training courses.

(7) The decontamination account is hereby established in the state treasury. All fees collected under this chapter shall be deposited in this account. Moneys in the account may only be spent after appropriation for costs incurred by the department in the administration and enforcement of this chapter.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# O. Contractor Final Report

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. ADMIN. CODE R.4-30-305(D) (2004).

**R4-30-305. D**. Final report.

1. A final report shall be:
   a. Prepared by the drug laboratory site remediation firm;
   b. Submitted to the owner of the remediated property and the county health department of the county in which the property is located; and
   c. Retained by the firm for a minimum of three years.
2. The final report shall include the following information and documentation:
   a. Complete identifying information of the real property, such as street address, mailing address, owner of record, legal description, county tax or parcel identification number, or vehicle identification number if a mobile home, registration number of the drug laboratory site remediation firm, name and certification number of the on-site supervisor, and name and certification numbers of the on-site workers that performed the remediation services on the residually contaminated portion of the real property;
   b. A summary of the remediation services completed on the residually contaminated portion of the real property, and any deviations from the approved work plan;
   c. Photographs documenting the remediation services and showing each of the sample locations, and a drawing or sketch of the residually contaminated areas that depict the sample locations;
   d. A copy of the sampling and testing results for VOCs and mercury, a copy of any asbestos sampling and testing results, a copy of the laboratory test results on all samples, and a copy of the chain-of-custody protocol documents for all samples from the residually contaminated portion of the real property;
   e. A summary of the waste characterization work, any waste sampling and testing results, and transportation and disposal documents, including but not limited to, bills of lading, weight tickets, and manifests for all materials removed from the real property;
   f. A summary of the on-site supervisor's observation and testing of the real property for evidence of burn areas, burn or trash pits, debris piles, or stained areas;
   g. A copy of any reports provided to the drug laboratory site remediation firm or prepared by the Certified Industrial Hygienist, Certified Safety Professional, an Arizona-registered geologist, and an Arizona-registered engineer; and
   h. A statement that the residually contaminated portion of the real property has been remediated in accordance with these standards.
3. Within 24 hours after the final report described in subsection (D)(1) of this Article has been prepared, the drug laboratory site remediation firm shall deliver, or send by certified mail, a copy of the final report to those individuals and entities identified in A.R.S. § 12-1000(A)(2), or a separate document stating that the residually contaminated portion of the real property has been remediated pursuant to A.R.S. § 12-1000(D).

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. ADMIN. R. § 333-040-0070(2)(J) (2004).

**333-040-0070(2)(J)**

(2) If contamination is found, the contractor shall proceed as follows to decontaminate the property, or to supervise the owner or agent of the owner in the decontamination:

. . .

(J) Documentation that the site to be decontaminated meets the criteria established in OAR 333-040-0065(2) or (3) when proposing an owner decontamination.

(b) After securing written approval from the Division for the work plan or amended work plan, the contractor shall complete the decontamination work, or supervise the completion of the work, in accordance with the approved work plan;

(c) The contractor shall arrange for, and supervise as necessary as set forth in OAR 333-040-0130(1), all follow-up sampling as specified in the approved work plan;

(d) The contractor shall submit to the Division written and photographic documentation showing that the decontamination has been completed in accordance with the approved work plan, along with all follow-up test results required by the approved work plan, and a completed affidavit on a form supplied by the Division attesting to compliance with the approved work plan; and

(e) If in the course of decontamination, factors are discovered requiring modifications to the work plan, such modifications may be made only upon prior written approval from the Division. The contractor shall provide the Division with written confirmation that the modified work as approved was performed.

(3) The contractor shall insure that all samples collected from the site, including the taking of air, surface and bulk samples prior to and after decontamination of the property are performed by independent, qualified personnel using industry-recognized standards and protocols. The contractor shall insure that the sampling personnel utilize the Division's Drug Lab Field and Sampling Guidelines.

(a) The contractor shall insure that all laboratory tests on the samples collected from the site are performed by a laboratory following standard laboratory practices. The laboratory shall:

(A) Be currently certified or approved under appropriate state, federal, or professional programs;

(B) Use standard methods and procedures when available;

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

(C) Have implemented a quality assurance program, including use of quality control measures, that is acceptable to the Division; and

(D) Have a US Drug Enforcement Administration registration on file with the Division if analyzing for controlled substances.

(b) The contractor shall insure that the following components of the site sampling and laboratory testing are integrated into the work plan:

(A) The materials, equipment and techniques used, or to be used, for sampling at each location;

(B) All control samples taken, or to be taken, including the location, materials, techniques and results;

(C) The exact location within the property where each test sample was or will be collected. Samples collected after decontamination shall be collected immediately adjacent to the location initially tested, and shall be sampled by identical methods in order to accurately reflect the effectiveness of the decontamination work; and

(D) The amount of area, volume of material or air taken, or to be taken, for each test sample: air sample test results are reported in ppm; liquid and solid sample test are reported in ppm, or in weight/weight; and surface sample test results are reported as total weight of contaminant per appropriate unit of area.

(c) All site assessment reports and test results shall be retained by the contractor for a period of not less than one calendar year from the date of certification of the site.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# P. Contractor Penalties

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE § 246-205-121 (2004).

**WAC 246-205-121 Denial, suspension, revocation of certification, and civil penalties.** (1) An initial, renewal, or reciprocal illegal drug manufacturing or storage site decontamination worker, supervisor, or contractor certificate will be denied when an applicant fails to meet the requirements of WAC 246-205-071, 246-205-081, 246-205-091 or 246-205-101.

(2) Disciplinary action against a decontamination worker, supervisor, or contractor may be taken for failing to comply with the requirements of chapter 64.44 RCW, or any rule adopted under chapter 64.44 RCW. Disciplinary action may be taken on any of the following grounds:

(a) Failing to perform decontamination, demolition, or disposal work under the supervision of trained personnel;

(b) Failing to file a work plan;

(c) Failing to perform work pursuant to the work plan;

(d) Failing to perform work that meets the requirements of the department;

(e) Obtaining a certificate by error, fraud, or misrepresentation; or

(f) If the person has been certified pursuant to RCW 74.20A.320 by the department of social and health services as a person who is not in compliance with a support order or a residential or visitation order. If the person has continued to meet all other requirements for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the department's receipt of a release issued by the department of social and health services stating that the person is in compliance with the order.

(3) Disciplinary action against a decontamination worker, supervisor, or contractor may include, but not be limited to, denial, suspension, or revocation of certification.

(4) A contractor may be assessed a civil penalty not to exceed five hundred dollars for each violation in addition to certification denial, suspension, or revocation pursuant to this rule. Each day the violation continues shall be considered a separate violation.

(5) Adjudicative proceedings are governed by chapter 34.05 RCW, the Administrative Procedure Act; chapter 246-10 WAC; and this chapter.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

## OR. ADMIN. R. § 333-040-0230 (2004).

**333-040-0230**

**Denial, Suspension, Revocation of License and Civil Penalties**

(1) An applicant for an initial license as a Drug Laboratory Decontamination Contractor will be denied if the applicant fails to meet any of the qualifications or requirements of these rules.

(2) The Division may deny, suspend or revoke the license of any contractor pursuant to ORS 453.888, ORS 183.310 to 183.550 and Oregon Laws 1999, chapter 849.

(3) Denials, suspensions and revocations of licenses are contested cases subject to ORS 183 and Oregon Laws 1999, chapter 849 and the model procedural rules of the Attorney General.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# Q. Civil Liability—Government Immunity

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. § 453.912 (2003).

**453.912 Governmental immunity from liability.** The state and any local government, their officers, agents and employees shall not be liable for loss or injury resulting from the presence of any chemical or controlled substance at a site used to manufacture illegal drugs or from actions taken to carry out the provisions of ORS 105.555, 431.175 and 453.855 to 453.912 except for liability for damages resulting from gross negligence or intentional misconduct by the state or local government. [1989 c.915 §21]

### WASH. REV. CODE ANN. § 64.44.080 (West 2004).

**RCW 64.44.080**
**Civil liability -- Immunity.**

Members of the state board of health and local boards of health, local health officers, and employees of the department of health and local health departments are immune from civil liability arising out of the performance of their duties under this chapter, unless such performance constitutes gross negligence or intentional misconduct.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# R. Sampling Procedures

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. ADMIN. CODE R.4-30-305 (B)(8) (2004).

**R4-30-305. Drug Laboratory Site Remediation Best Standards and Practices**
B. Remediation procedures for the residually contaminated portion of the real property.

. . .

8. Procedures for Plumbing, Septic, Sewer, and Soil.
   a. All plumbing inlets to the septic/sewer system, including but not limited to sinks, floor drains, bath tubs, showers, and toilets, shall be visually assessed for any staining or other visible residual contamination. All plumbing traps shall be assessed for VOC concentrations with a PID or FID, and for mercury vapors, by using a mercury vapor analyzer. If VOC concentrations or mercury vapor concentrations exceed the post-remediation clearance levels contained in subsections (C)(2) and (C)(3) of this rule, the accessible plumbing and traps where the excess levels are found shall be removed and properly disposed of, or shall be cleaned and tested to meet the post-remediation clearance levels contained in R4-30-305(C)(2) and (C)(3).
   b. The on-site supervisor shall determine if the dwelling is connected to a local sewer system or to an on-site septic system. If the dwelling is connected to an on-site septic system, a sample of the septic tank liquids shall be obtained and tested for VOC concentrations.
      i. If VOCs are not found in the septic tank sample or are found at concentrations less than AWQS or less than 700 micrograms per liter (mg/l) for acetone, no additional work is required in the septic system area, unless requested by the owner of the real property.
      ii. If VOCs are found in the septic tank at concentrations exceeding the AWQS or exceeding 700 mg/l for acetone the following shall apply:
         (1) The discharge area such as the leach field, seepage pit, and evaporation mounds shall be investigated under the direct supervision of an Arizona-registered geologist or an Arizona-registered engineer;
         (2) The septic system discharge area shall be investigated for VOCs and unless there is clear evidence that mercury or lead was not used in the manufacturing of methamphetamine, LSD or ecstasy at the clandestine drug laboratory, the septic system discharge area shall also be investigated for mercury and lead;
         (3) The vertical extent of any VOCs, mercury, and lead detected in the soil samples shall be delineated to concentrations below laboratory detection limits or to background concentrations, and the horizontal extent of the VOCs, mercury and lead shall be delineated to concentrations below each compound's SRL;
         (4) If any of the VOCs, mercury, and lead used by the clandestine drug laboratory migrated down to groundwater level, the extent of groundwater contamination shall also be investigated under the direct

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

supervision of an Arizona-registered geologist or an Arizona-registered engineer and the vertical and horizontal extent of the groundwater contamination shall be delineated to concentrations below the AWQS or below 700 mg/l for acetone; and

(5) After complete characterization of the release, the impacted soils shall be remediated to concentrations below the SRL or background concentrations, and any impacted groundwater shall be remediated to concentrations below the AWQS or below 700 mg/l for acetone.

c. The on-site supervisor shall observe the real property for evidence of burn areas, burn or trash pits, debris piles or stained areas. The on-site supervisor shall test any burn areas, burn or trash pits, debris piles or stained areas with appropriate testing equipment, such as, a LEL/O2 meter, pH paper, PID, FID, mercury vapor analyzer or equivalent equipment.

i. If the burn areas, burn or trash pits, debris piles, or stained areas are not part of the residually contaminated portion of the real property, the drug laboratory site remediation firm shall recommend to the owner of the real property that these areas be investigated. If the owner advises the drug laboratory site remediation firm not to investigate these areas, the drug laboratory site remediation firm shall take appropriate action pursuant to R4-30-301.

ii. If the burn areas, burn or trash pits, debris piles or stained areas are part of the residually contaminated portion of the real property, these areas shall be investigated and remediated by the drug laboratory site remediation firm.

(1) Any wastes remaining from the operation of the clandestine drug laboratory or other wastes impacted by compounds used by the clandestine drug laboratory shall be characterized, removed, and properly disposed of.

(2) Any potentially impacted soil and/or groundwater shall be investigated under the direct supervision of an Arizona-registered geologist or an Arizona-registered engineer.

(3) The burn areas, burn or trash pits, debris piles, or stained areas shall be investigated for the VOCs used by the drug laboratory. Unless there is clear evidence that mercury or lead was not used in the manufacturing of methamphetamine, LSD, or ecstasy at the clandestine drug laboratory, the burn areas, burn or trash pits, debris piles, or stained areas shall be investigated for lead and mercury.

(4) The vertical extent of any VOCs, lead, or mercury detected in the soil samples shall be delineated to concentrations below laboratory detection limits or to background concentrations. The horizontal extent of these compounds shall be delineated to concentrations below each compound's SRL.

(5) If any of the compounds used by the clandestine drug laboratory migrated down to groundwater level, the extent of groundwater contamination shall also be investigated under the direct supervision of an Arizona-registered geologist or an Arizona-registered engineer. The

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

vertical and horizontal extent of the groundwater contamination shall be delineated to concentrations below the AWQS and below 700 mg/l for acetone.

(6) After complete characterization of the release, the impacted soils shall be remediated to concentrations below the SRL or background concentrations, and any impacted groundwater shall be remediated to concentrations below the AWQS and below 700 mg/l for acetone.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE § 246-205-531 (2004).

**WAC 246-205-531 Sampling procedures.** (1) The analytical results obtained through sampling may be used as a method to determine contamination. Types of sample collection include, but are not limited to:

(a) Nonporous surface;

(b) Porous surface;

(c) Air;

(d) Drinking water;

(e) Ground water;

(f) Surface water;

(g) Soil; and

(h) Septic system.

(2) Collection of samples shall be performed by department of ecology staff; department of health certified CDL supervisors; or local health officers using:

(a) Standards and protocols to ensure accuracy and the ability to produce similar results with repeated sampling;

(b) Proper swabbing techniques to collect a representative sample of the area being sampled; and

(c) Proper care and prudent action to avoid contamination during sampling.

(3) All samples collected, transported, stored, and analyzed under the provisions of this section must be secured to assure an unbroken chain-of-custody as described in the American Society of Testing Materials Standard D 4840.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# S. Decontamination Standards/Decontamination Verification Procedures

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. ADMIN. CODE R.4-30-305 (C) (2004).

**R4-30-305. Drug Laboratory Site Remediation Best Standards and Practices**

. . .

C. Post-Remediation Testing Procedures.

1. Post-remediation sampling shall be conducted under the direct supervision of a Certified Industrial Hygienist, a Certified Safety Professional, Arizona-registered geologist or an Arizona-registered engineer. The individual taking the samples shall have experience with the remediation of hazardous substances, with confirmation sampling of remedial projects, and with evaluating health risks and exposures to chemicals. All sampling used to verify that no additional removal or cleaning is required shall be conducted under the direct supervision of a Certified Industrial Hygienist, Certified Safety Professional, Arizona-registered geologist or an Arizona-registered engineer. All sample locations shall be photographed for documentation purposes, and these photographs shall be included in the final report.
2. The drug laboratory site remediation firm shall conduct sampling and testing for all of the compounds listed below. All remediated areas and materials shall meet the following post-remediation clearance levels:

| Compound | Remediation Standard |
|---|---|
| Red Phosphorus | Removal of stained material or cleaned pursuant to these standards |
| Iodine Crystals | Removal of stained material or cleaned pursuant to these standards |
| Methamphetamine | 0.1 μg Methamphetamine/100 $cm^2$ |
| Ephedrine | 0.1 μg Ephedrine/100 $cm^2$ |
| Pseudoephedrine | 0.1 μg Pseudoephedrine/100 $cm^2$ |
| VOCs in Air | VOC air monitoring < 1 ppm |
| Corrosives | Surface pH of 6 to 8 |
| LSD | 0.1 μg LSD/100 $cm^2$ |
| Ecstasy | 0.1 μg Ecstasy/100 $cm^2$ |

3. The drug laboratory site remediation firm shall conduct sampling and testing for all of the metals listed below in all cases except where there is clear evidence that these metals were not used in the manufacturing of methamphetamine, LSD, or ecstasy at the drug laboratory:

| Compound | Remediation Standard |
|---|---|
| Lead | 4.3 μg Lead/100 $cm^2$ |

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

Mercury 3.0 μg Mercury/$m^3$ air

4. All sampling and testing shall be conducted in accordance with the following procedures:
   a. All sample locations shall be photographed, and the photographs shall be included in the final report.
   b. All sample locations shall also be shown on a floor plan of the residually contaminated portion of the real property, and the floor plan shall be included in the final report.
   c. All samples shall be obtained from areas representative of the materials or surfaces being tested. All samples shall be obtained, preserved, and handled in accordance with industry standards for the types of samples and analytical testing to be conducted and maintained under chain-of-custody protocol.
   d. The individual conducting the sampling shall wear a new pair of gloves to obtain each sample.
   e. All reusable sampling equipment shall be decontaminated prior to sampling.
   f. All testing equipment shall be properly equipped and calibrated for the types of compounds to be analyzed.
   g. Methamphetamine, ephedrine, pseudoephedrine, ecstasy, and/or LSD sampling and testing:
      i. Whatman 40 ashless filter paper or equivalent shall be used for all wipe sampling. The filter paper shall be wetted with analytical grade methanol for the wipe sampling. The filter paper shall be blotted or wiped at least five times in two perpendicular directions within each sampling area. The same filter paper may be used for up to three wipe areas or a new filter paper may be used for each area, and the three filter papers combined for analytical testing.
      ii. Three 10 cm x 10 cm areas (100 $cm^2$) shall be wipe sampled from each room of the residually contaminated portion of the real property. The three samples shall be obtained from the non-porous floor, one wall, and the ceiling in each room.
      iii. Three 10 cm x 10 cm areas (100 $cm^2$) shall be wipe sampled from different areas of the ventilation system.
      iv. If there is a kitchen in the residually contaminated portion of the real property, three 10 cm x 10 cm areas (100 $cm^2$) shall be wipe sampled from a combination of the counter top, sink, or stove top, and from the floor in front of the stove top.
      v. If there is a bathroom in the residually contaminated portion of the real property, three 10 cm x 10 cm areas (100 $cm^2$) shall be wipe sampled from a combination of the counter top, sink, toilet, and the shower/bath tub.
      vi. If there are any cleaned appliances in the residually contaminated portion of the real property, one 10 cm x 10 cm area (100 $cm^2$) shall be wipe sampled from the exposed portion of each appliance. If multiple appliances are present, each wipe sample may be a composite of up to three 100 $cm^2$ areas on three separate appliances.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

vii. After sampling, the wipe sample shall be placed in a new clean sample jar and sealed with a teflon-lined lid. The sample jar shall be properly labeled with at least the site or project identification number, date, time, and actual sample location. The sample jar shall be placed in a cooler with ice until delivered to an analytical laboratory licensed in any state in the United States to perform GC/MS testing. The sample shall be analyzed for methamphetamine, ephedrine, pseudoephedrine, LSD, and/or ecstasy, depending upon the type of clandestine drug laboratory, using a GC/MS instrument, or equivalent.

h. VOC sampling and testing procedures:

i. A properly calibrated PID or FID capable of detecting VOCs shall be used for testing. The background concentration of VOCs shall be obtained by testing three exterior areas outside the limits of the residually contaminated portion of the real property and in areas with no known or suspected sources of VOCs. All VOC readings shall be recorded for each sample location.

ii. At least three locations in each room of the residually contaminated portion of the real property shall be tested for VOC readings. The testing equipment probe shall be held in the sample location for at least 30 seconds to obtain a reading; and

iii. All accessible plumbing traps shall be tested for VOCs by holding the testing equipment probe in the plumbing pipe above the trap for at least 60 seconds.

i. pH testing procedures:

i. Surface pH measurements shall be made using deionized water and pH test strips with a visual indication for a pH between 6 and 8. The pH reading shall be recorded for each sample location.

ii. For horizontal surfaces, deionized water shall be applied to the surface and allowed to stand for at least three minutes. The pH test strip shall then be placed in the water for a minimum of 30 seconds and read.

iii. For vertical surfaces, a Whatman 40 ashless filter paper or equivalent filter paper shall be wetted with deionized water and wiped over a 10 cm x 10 cm area at least five times in two perpendicular directions. The filter paper shall then be placed into a clean sample container and covered with deionized water. The filter and water shall stand for at least three minutes prior to testing. The pH test strip shall then be placed in the water for a minimum of 30 seconds and read.

iv. pH testing shall be conducted on at least three locations in each room within the areas with visible contamination and within areas known to store or handle chemicals used for the clandestine drug laboratory in the residually contaminated portion of the real property.

j. Lead Sampling and Testing Procedures:

i. Unless there is clear evidence that lead was not used in the manufacturing of methamphetamine, LSD, or ecstasy at the clandestine drug laboratory, lead sampling shall be conducted as follows:

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

(1) Whatman 40 ashless filter paper or equivalent shall be used for wipe sampling. The filter paper shall be wetted with analytical grade 3% nanograde nitric acid for the wipe sampling. The filter paper shall be blotted or wiped at least five times in two perpendicular directions within each sampling area. The same filter paper may be used for up to three wipe areas or a new filter paper may be used for each area and the three filter papers combined for analytical testing;

(2) Three 10 cm x 10 cm areas (100 $cm^2$) shall be sampled in each room within the areas with visible contamination or within areas known to store or handle chemicals used for the clandestine drug laboratory in the residually contaminated portion of the real property; and

(3) After sampling, the wipe sample shall be placed in a new clean sample jar and sealed with a teflon-lined lid. The sample jar shall be properly labeled with at least the site or project identification number, date, time, and actual sample location. The sample jar shall be placed in a cooler with ice until delivered to an Arizona-licensed analytical laboratory.

ii. The sample shall be analyzed for lead using EPA Method 6010B or equivalent.

k. Mercury Sampling and Testing Procedures:

i. A properly calibrated mercury vapor analyzer shall be used for evaluating the remediated areas for the presence of mercury. All mercury readings shall be recorded for each sample location.

ii. At least three locations in each room within the areas with visible contamination or within areas known to store or handle chemicals used for the clandestine drug laboratory in the residually contaminated portion of the real property shall be tested for mercury vapor readings. The testing equipment probe shall be held in the sample location for at least 30 seconds to obtain a reading.

iii. All accessible plumbing traps shall be tested for mercury by holding the testing equipment probe in the plumbing pipe above the trap for at least 60 seconds.

l. Septic Tank Sampling and Testing Procedures:

i. The liquid in the septic tank shall be sampled with a new clean bailer or similar equipment.

ii. The liquid shall be decanted or poured with minimal turbulence into three new VOA vials properly prepared by the laboratory.

iii. The VOA vials shall be filled so that there are no air bubbles in the sealed container. If air bubbles are present, the vial must be emptied and refilled;

(1) The sample vials shall be properly labeled with at least the date, time, and sample location;

(2) The sample vials shall be placed in a cooler with ice until delivered to an Arizona- licensed analytical laboratory; and

(3) The sample shall be analyzed for acetone and methanol using EPA Method 8015B or equivalent.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE § 246-205-541 (2004).

**WAC 246-205-541 Decontamination standards.** The decontamination standards include:

(1) Methamphetamine of less than or equal to 0.1 micro grams per 100 square centimeters;

(2) Total lead of less than or equal to 20 micro grams per square foot;

(3) Mercury of less than or equal to 50 nano grams per cubic meter in air; and

(4) Volatile organic compounds (VOCs) of 1 part per million total hydrocarbons and VOCs in air.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# T. Recording Decontamination

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### WASH. ADMIN. CODE § 246-205-590 (2004).

**WAC 246-205-590 Recording decontamination.** If, after review of the information in WAC 246-205-580, the local health officer determines the property has been decontaminated, the local health officer shall within ten working days:

(1) Record a release for reuse document in the real property records of the county auditor where the property is located indicating that to the best of his or her knowledge, the property was decontaminated in accordance with this chapter.

(2) Send a copy of the release to the property owner.

(3) Send a copy of the release to the state department of health.

(4) Send a copy of the release to the local building or code enforcement department.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# U. Buyer/Seller Disclosure and Transfer Requirements

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### ARIZ. REV. STAT. ANN. §§ 12-1000(F), (G) (West 2004).

**12-1000. Clandestine drug laboratories; notice; cleanup; residual contamination; civil penalty; immunity; restitution; violation; classification**

. . .

**(F)1.** Within five days after a buyer signs a contract to purchase the real property, the owner shall notify the buyer in writing that methamphetamine, ecstasy or LSD was manufactured on the real property or that an arrest was made pursuant this section. The buyer shall acknowledge receipt of the notice. A buyer may cancel the real estate purchase contract within five days after receiving the notice. If the owner does not comply with this paragraph, the buyer may cancel the purchase contract.

2. The landlord shall notify a prospective tenant for a dwelling unit that was the subject of the notice in writing that methamphetamine, ecstasy or LSD was manufactured on the real property or that an arrest was made pursuant this section. The tenant shall acknowledge receipt of the notice before taking possession of the real property or before signing a rental agreement for the real property. The notice shall be attached to the rental agreement. If the landlord does not comply with this paragraph, the tenant may void the rental agreement.

3. Before a customer occupies a room that was the subject of the notice, the owner or manager shall notify the customer in writing that methamphetamine, ecstasy or LSD was manufactured in the room or that an arrest was made pursuant to this section. If the owner or manager does not comply with this paragraph, the customer may void the agreement.

4. The owner shall notify a buyer or prospective tenant in writing that methamphetamine, ecstasy or LSD was manufactured in the mobile home or recreational vehicle or that an arrest was made pursuant to this section. The buyer shall acknowledge receipt of the notice before taking possession of the mobile home or recreational vehicle. A buyer may cancel the purchase contract within five days after receiving the notice. The tenant shall acknowledge receipt of the notice before taking possession of the mobile home or recreational vehicle or before signing a rental agreement for the mobile home or recreational vehicle. The notice shall be attached to the rental agreement: If the owner does not comply with this paragraph, the tenant may void the rental agreement.

5. If a mobile home or recreational vehicle in a space rental park contains a clandestine drug laboratory, the landlord, on receipt of a notice pursuant to this section, shall notify the lienholder of record and the owner of record of the unit to remove it from the park within thirty days. If the unit is not removed within thirty days, the landlord may remove or demolish the unit and dispose of it as junk and shall notify the department of transportation of the demolition. A landlord that complies with this subsection is not liable for such action.

**G.** If an owner fails to provide any notice required by this section, the owner is subject to a civil penalty of one thousand dollars and is liable for any harm resulting from the owner's failure to comply with the requirements of this section.

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

## DIRECTORY OF EXAMPLES OF CLEANUP AND REMEDIATION STATUTES, REGULATIONS, & LOCAL ORDINANCES

### OR. REV. STAT. §§ 453.867, -870 (2003).

**453.867 Restriction on transfer of property used as illegal drug manufacturing site; contracts voidable.** (1) Unless determined fit for use, pursuant to ORS 105.555, 431.175 and 453.855 to 453.912 and rules of the Department of Human Services, or as authorized by ORS 453.870, no person shall transfer, sell, use or rent any property knowing or having reasonable grounds to believe it was used as an illegal drug manufacturing site.

(2) All contracts, oral or written, for the transfer, sale, use or rent of property in violation of subsection (1) of this section are voidable between the parties, at the instance of the purchaser, transferee, user or renter. This subsection shall not make voidable any promissory note or other evidence of indebtedness or any mortgage, trust deed or other security interest securing such a promissory note or evidence of indebtedness, where such note or evidence and any such mortgage, trust deed or other security interest were given to a person other than the person transferring, selling, using or renting the property to induce such person to finance the transfer, sale, use or rental of the property. This section shall not impair obligations or duties required to be performed upon termination of a contract, as required by the provisions of the contract, including but not limited to payment of damages or return of refundable deposits. [1989 c.915 §4]

**453.870 Transfer allowed after full disclosure.** (1) Any property that is not fit for use as determined under ORS 453.876 may be transferred or sold if full, written disclosure, as required by rules of the Department of Human Services, is made to the prospective purchaser, attached to the earnest money receipt, if any, and shall accompany but not be a part of the sale document nor be recorded. However, such property shall continue to be subject to the provisions of ORS 453.876, regardless of transfer or sale under this section.

(2) Any transferee or purchaser who does not receive the notice described in subsection (1) of this section may set aside the transfer or sale as voidable and bring suit to recover damages for any losses incurred because of the failure to give such notice.

(3) The transferor or seller of any property described in subsection (1) of this section shall notify the department of the transfer or sale as required by rule of the department. [1989 c.915 §5]

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

# V. Cleanup and Nuisance Ordinances

© 2004 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. Phone: (703) 836-6100. Research current through August 20, 2004.

Olmstead County, Minn., Resolution 01-99 (Oct. 23, 2001)

# OLMSTED COUNTY
# CLEANUP OF CLANDESTINE DRUG LAB SITES ORDINANCE

Adopted by OLMSTED COUNTY BOARD
Resolution No.01-99 on October 23, 2001

## ARTICLE I. GENERAL PROVISIONS


SECTION 1.10 TITLE
SECTION 1.20 PURPOSE
SECTION 1.30 JURISDICTION
SECTION 1.40 INTERPRETATION AND APPLICATION
SECTION 1.50 DISCLAIMER OF LIABILITY
SECTION 1.60 FEES
SECTION 1.70 DEFINITIONS, RULES, AND WORD USAGE


## ARTICLE II. ADMINISTRATION


SECTION 2.00 DECLARATION OF PROPERTY AS A CHEMICAL INVESTIGATION SITE PUBLIC HEALTH NUISANCE
SECTION 2.10 MEDICAL PROTOCOL FOR ASSESSING HEALTH STATUS
SECTION 2.20 LAW ENFORCEMENT NOTICE TO AFFECTED PUBLIC, PUBLIC HEALTH, AND CHILD PROTECTION AUTHORITIES
SECTION 2.30 NOTICE OF CHEMICAL INVESTIGATION SITE PUBLIC HEALTH NUISANCE HAZARD TO OWNER AND OCCUPANTS
SECTION 2.40 NOTICE FILED WITH PROPERTY RECORD AND/OR MOTOR VEHICLE RECORDS
SECTION 2.50 PROPERTY OWNER'S AND OCCUPANT'S RESPONSIBILITY TO ACT
SECTION 2.60 PROPERTY OWNER'S RESPONSIBILITY FOR COSTS AND OPPORTUNITY FOR RECOVERY
SECTION 2.70 SPECIAL ASSESSMENT TO RECOVER PUBLIC COSTS
SECTION 2.80 AUTHORITY TO MODIFY OR REMOVE DECLARATION OF CHEMICAL INVESTIGATION SITE PUBLIC HEALTH NUISANCE
SECTION 2.90 WASTE GENERATED FROM CLEANING UP A CLANDESTINE DRUG LAB


## ARTICLE III. EXCEPTIONS AND APPEALS


SECTION 3.10 CHALLENGES TO ADMINISTRATION OF ORDINANCE
SECTION 3.20 SEVERABILITY AND SAVINGS CLAUSE


## ARTICLE IV. EFFECTIVE DATE

# CLEANUP OF CLANDESTINE DRUG LAB SITES ORDINANCE

## ARTICLE I. GENERAL PROVISIONS

SECTION 1.10 Title
This ordinance shall be known and referenced as the "Cleanup of Clandestine Drug Lab Sites Ordinance."

SECTION 1.20 Purpose
1.21 Professional reports, based on assessments, testing, and investigations, show that chemicals used in the production of illicit drugs can condense, penetrate, and contaminate surfaces, furnishings, and equipment of surrounding structures.

1.22 These conditions present health and safety risks to occupants and visitors of structures through fire, explosion, skin and respiratory exposure to chemicals.

1.23 This ordinance establishes responsibilities and guidelines for involved parties to assure the following:
a) people are not unnecessarily exposed to the dangers of these contaminated structures; and
b) proper steps are taken to remove contaminates and assure appropriate tests are done to demonstrate that affected structures are sufficiently cleaned for human contact.

1.24 This ordinance assists and guides appropriate authorities, property owners, and occupants to prevent injury and illness to members of the public, particularly children.

1.25 This ordinance is intended to help assure reduction of peoples exposure to chemicals associated with the site of a former clandestine drug lab operation at structures such as a dwelling, building, motor vehicle, trailer, or appliance.

SECTION 1.30 Jurisdiction
1.31 This ordinance shall apply to all incorporated and unincorporated municipalities (city or township) within the boundaries of Olmsted County.

1.32 Where a municipality has lawfully passed an ordinance to regulate and enforce in an equivalent or more restrictive manner, the County's administrator of this ordinance shall coordinate regulation and enforcement with that municipality.

SECTION 1.40 Interpretation and Application
1.41 The provisions of this ordinance shall be interpreted and applied as the minimum requirements necessary to protect public health, safety, and welfare.

1.42 Where the conditions imposed by any provision of this ordinance are either more restrictive or less restrictive than comparable provisions imposed by any other law, ordinance, statute, resolution, or regulation of any kind, the regulations which are more restrictive or which impose higher standards or requirements shall prevail.

SECTION 1.50 Disclaimer Of Liability
Liability on the part of, or a cause of action against, Olmsted County or any employee thereof for any damages that may result from reliance on this ordinance shall be eliminated or limited as provided by Minnesota law and the Olmsted County Environmental Services Administrative Ordinance.

SECTION 1.60 Fees
Fees for the administration of this ordinance may be established and amended periodically by resolution at the Olmsted County Board.

SECTION 1.70 Definitions, Rules, and Word Usage
For the purpose of this ordinance, the following terms or words shall be interpreted as follows:

1.71 Child means any person less than 18 years of age.

1.72 Chemical investigation site means a clandestine drug lab site that is under notice and order for cleanup and/or remediation as a public health nuisance, as authorized by Minnesota Statute Chapter 145A, and this ordinance.

1.73 Clandestine drug lab operation means the unlawful manufacture or attempt to manufacture a controlled substance within any area of a structure such as a dwelling, building, motor vehicle, trailer, boat, or other appliance.

1.74 Clandestine drug lab site means any parts of a structure such as a dwelling, building, motor vehicle, trailer, or appliance occupied or affected by conditions and/or chemicals, typically associated with a clandestine drug lab operation.

1.75 Cleanup means proper removal and/or containment of substances hazardous to humans and/or the environment at a chemical investigation site. Cleanup is a part of remediation.

1.76 Controlled substance means a drug, substance or immediate precursor in Schedules I.
through V. of Minnesota Statute § 152.02, as amended in the future. The term shall not include distilled spirits, wine, malt beverages, intoxicating liquors, or tobacco.

1.77 Owner means any person, firm, or corporation who owns, in whole or in part, the land and/or structures such as buildings, motor vehicle, trailer, boat or other appliance at a clandestine drug lab site.

1.80 Public health nuisance shall have the meaning attributed to it in Minnesota Statutes § 145A.02, Subd. 17.

1.81 Remediation means methods such as assessment, evaluation, testing, venting, detergent scrubbing, enclosure, encapsulation, demolition, and/or removal of contaminated materials from a chemical investigation site.

1.82 Structure means a dwelling, building, motor vehicle, trailer, boat or other appliance.

## ARTICLE II. ADMINISTRATION

SECTION 2.00 Declaration of Site as a Chemical Investigation Site Public Health Nuisance
Clandestine drug lab sites as defined above are declared by this ordinance to be "chemical investigation site public health nuisances".

SECTION 2.10 Medical protocol for assessing health status of exposed persons
A medical protocol for assessing the health status and determining medical care needs of persons – particularly children – that are found or known to be frequent visitors at a clandestine drug lab site, may be established by the Medical Consultant to Public Health, as a Standing Order that may be updated as necessary by the Medical Consultant.

SECTION 2.20 Law Enforcement notice to affected public, public health, and child protection authorities

2.21 Law enforcement authorities who identify a clandestine drug lab site, or clandestine drug lab operation shall promptly notify the Olmsted County departments responsible for public health and child protection.

2.22 The obligation to promptly notify may be delayed to accomplish appropriate law enforcement objectives, but only to the extent that public health and child protection responsibilities are not unnecessarily compromised.

2.23 When law enforcement completes their work and is prepared to leave such sites, they shall leave a warning sign posted on the entrance of the affected part of the structure. The warning sign shall be those that have been prepared in advance for such situations through the collaboration of County Law Enforcement and Public Health. The warning sign shall be of a size and contain information sufficient to alert visitors or returning occupants to the site that the area is a chemical investigation site, may be dangerous to enter, and must not be entered except by authorization of the Public Health and/or Law Enforcement agency identified on the sign.

2.24 The notices, referenced in Sec 2.21 above, shall include sufficient information to inform the recipients of the following:
a) property location by street address and other identifiable location;
b) property owner's and occupant's identities – especially the identities of any children and women of child-bearing age found or known to be associated with the site;
c) chemicals found and indications of chemical residues;
d) presumed duration of the lab;
e) equipment in a dwelling or structure that is typically associated with the manufacture of a controlled substance; and
f) conditions typically associated with a clandestine drug lab site or operation including, weapons, illicit drugs, filth, fire, or electrical shock and other harmful conditions as determined by Minnesota law.

SECTION 2.30 Notice of Chemical Investigation Site Public Health Nuisance to Owner and Occupant

2.31 After Public Health receives adequate information from law enforcement that they have identified a clandestine drug lab site and posted the appropriate Chemical Investigation Site Public Health Nuisance sign, Public Health shall act to contact the lawful occupants and owners of the site to also inform them of their responsibilities relative to the chemical investigation site public health nuisance.

2.32 The public health authority shall notify and order the property owner and occupant to have the public health nuisance removed or abated as provided in Minnesota Statute § 145A.04 and this ordinance. Public Health shall include the following as part of the notice and order:

a) A replica of the Chemical Investigation Site Public Health Nuisance declaration that is posted at the site's entrance(s).
b) Information about the potentially hazardous condition of the dwelling.
c) A summary of the property owner's and occupant's responsibilities under this ordinance.
d) Information that can help them locate appropriate services necessary to remove and resolve the chemical investigation site public health nuisance status as provided in this Ordinance and Minnesota Statute § 145A.04.

2.33 The public health authority shall also provide information about the Chemical Investigation Site Public Health Nuisance declaration and potential hazard(s) to the following concerned parties:

a) Occupants of the affected structure;
b) Neighbors in proximity that can be reasonably affected by the conditions found;
c) The local municipal clerk;
d) Local law enforcement;
e) Other state and local authorities, such as the Minnesota Pollution Control Agency and Minnesota Department of Health, that may have public and environmental protection responsibilities applicable to the situation.

SECTION 2.40 Notice Filed with Property Record and/or Motor Vehicle Record

2.41 If after 10 days notice and order, Public Health is unable to obtain any reasonable assurance or plan from the property owner or occupant that the dwelling or structure is being properly vacated, cleaned, remediated, and tested, Public Health is authorized to provide a copy of the Chemical Investigation Site Public Health Nuisance notice and order to the County Recorder and to the lien and mortgage holders of the affected structure and/or properties. The County Recorder is authorized to file that information with the property record, to help assure that persons with interest in the property have access to information about the property's chemical investigation site public health nuisance status.

2.42 Similarly when the affected property is a motor vehicle, boat, or trailer, Public Health shall notify the appropriate State and local agency that maintains motor vehicle, boat, or trailer records, and to the lien and mortgage holders of the affected properties.

SECTION 2.50 Property Owner's and Occupant's Responsibility to Act

2.51 Property owner(s) and occupant(s) provided with a notice, which may include the posted warning notice informing them about the chemical investigation site public health nuisance, shall promptly act to vacate occupants from those parts of a structure that are a chemical investigation site public health nuisance. This includes dwellings, buildings, motor vehicles, trailers, boat, or appliances.

2.52 Within ten business days of receiving the Public Health notice and order to cleanup the Chemical Investigation Site Public Health Nuisance, the property owner(s) and/or occupant(s) shall act to accomplish the following:

a) Notify Public Health Authority that the affected parts of the dwellings, buildings, and/or motor vehicles have been and will remain vacated and secured until Public Health acts to remove the chemical hazard investigation public health nuisance declaration.

b) Contract with one or more acceptable environmental hazard testing and cleaning firms (acceptable firms are those that have provided the Minnesota and/or Olmsted County Departments of Health assurance of appropriate equipment, procedures, and personnel) to accomplish the following:
   1) Conduct a detailed on-site assessment,
   2) Determine the extent of contamination
   3) Carry out and/or direct remediation operations,
   4) Perform and/or direct follow-up sampling and testing, and
   5) Determine that the risks are sufficiently reduced, according to Minnesota Department of Health guidelines, to allow renewed occupancy of the dwelling.

c) Provide the Public Health Authority with the identity of the testing and cleaning firm the owner has contracted with, for remediation of the structure(s) as described above.

d) Provide the Public Health Authority with the contractor's plan and schedule for remediation leading to removal of the chemical investigation site public health nuisance declaration.

e) The property owner or occupant may also seek authorization for an extension of time to allow the owner time to consider options for arranging cleanup or removal of the affected parts of the structure. Owner or occupant must show good cause for any such extension. Any such extension shall be dependant on the owner's assurance that the affected parts of the structure will not be occupied pending appropriate cleanup or demolition.

f) The Public Health Authority may authorize extensions, up to 90 calendar days but will make extensions beyond 90 days only with approval of the Environmental Commission.

SECTION 2.60 <u>Property Owner's Responsibility for Costs and Opportunity for Recovery</u>

2.61 Consistent with Minnesota Statutes Chapter 145A, the property owner shall be responsible for a) private contractor's fees, cleanup, remediation, and testing of chemical investigation site public health nuisance conditions; and b) Olmsted County's fees and costs of administering notices and enforcing vacating, cleanup, remediation, and testing of affected parts of the property.

2.62 Nothing in this ordinance is intended to limit the property owners, occupants, or the County's right to recover costs, referenced in this section, from persons contributing to the damage, such as the operators of the clandestine drug lab and/or other lawful sources.

2.63 The County's administrative and enforcement services, referenced in subsection 2.61, include but are not limited to, the following:
   a) Posting the site,
   b) Notification of concerned parties,
   c) Remediation services,
   d) Laboratory fees,
   e) Expenses related to the recovery of costs, including the property assessment process,
   f) Administrative fees, and
   g) Other services associated with assessing, vacating, and remediation of the property.

2.64 The County will pay remediation costs that exceed the following:

a) Any applicable insurance damage recovery payments;
b) Any applicable security deposits;
c) Any applicable court awards, settlements, or payments made for damage recovery from the perpetrator. This includes those recoveries made according to the authority of Minnesota Statutes Chapters 115B and 611A and Minnesota Statute 561.01; and
d) The property owner's contribution of $ 2,000 (two thousand dollars) .
e) An individual property owner's contribution amount may be adjusted down according to current poverty guidelines accepted by the County Board of Commissioners.

2.65 When a property owner transfers remediation costs to the County, the property owner agrees to provide the following to the County: 1) identity of all insurance companies, that have policies regarding the property, and pending court or contract enforcement actions, that may result in recovery of remediation costs; and 2) proceeds from pending recovery actions, including, but not limited to, insurance companies, applicable court actions, and enforcement of contracts. As a precondition to any County obligation to make any payments hereunder, the property owner shall make legally sufficient assignment to the County any of the foregoing which are applicable.

2.66 If there is still an unresolved cost, the County shall apply for applicable state and federal funding to offset the cost of remediation and associated eligible County expenses.

a) Such funding may include that authorized by federal programs such as the Environmental Protection Agency's "Local Government Reimbursement" program referenced in pages 8283 – 8296 of the Federal Register, dated February 18, 1998.

b) The County shall return amounts that exceed the County's applicable costs to the rightful parties.

c) Costs that exceed the financial sources, referenced in the above sections, will be recovered from the property owner as a special assessment on the property as provided in Minnesota Law and Section 2.70 below.

2.67 The County Board of Commissioners can periodically amend the considerations and financial contribution limits, referenced in section 2.64 through 2.66 by resolution.

2.68 Expenses, such as replacement of a structure's damaged furnishings, walls, floors, and ceilings; and equipment, vehicles, boats, and trailers are not eligible for County funding referenced in this ordinance.

SECTION 2.70 Special Assessment to Recover Public Costs

2.71 The County is authorized to proceed within ten business days after mailing of notification, to initiate the assessment and cleanup when a) the property owner is not located, or b) is located but fails to respond appropriately, or c) notifies Public Health authority that he or she refuses to, or cannot pay the costs, or arrange timely assessment and cleanup that is acceptable to the designated Public Health authority.

2.72 The County Administrator (or the Administrator's formally identified designee) shall be fully authorized to act, consistent with Minnesota Law, on behalf of the County to direct funds to assure prompt remediation of chemical investigation sites.

2.73 When the estimated cost of testing, cleanup, and remediation exceeds seventy five percent of the County Assessor's market value of the structure, the County Administrator (or the Administrator's formally identified designee) is authorized to notify the property owner of the county's intent to remove and dispose of the affected property instead of proceeding with cleaning and remediation.

2.74 The property owner will be given up to ten business days to appeal to the County Administrator (or the Administrator's formally identified designee) and if appealed will be given the opportunity to show cause as to why such removal should not occur. The appeal is also the owner's opportunity to assume responsibility and provide acceptable plans and schedule for effectively cleaning, remediation, and testing of the structure. If within ten business days, of the administrator's notice, the owner fails to appropriately appeal or assume responsibility the administrator is authorized to arrange removal and disposition of the hazardous structure.

2.75 The property owner shall reimburse the county, for it's fees and costs of vacating, securing, and assuring cleanup and testing of the affected parts of the structure. Fees and costs not paid in any other way, may be collected through a special assessment on the property, as allowed by applicable Federal, State, and County Laws, Ordinances, and/or applicable County Board Resolution.

2.76 Payment, on the special assessment, shall be at the annual rate of at least one thousand dollars ($1000) or more as needed to assure full payment to the County within ten (10) years. This amount shall be collected at the time real estate taxes are due. The amount due and/or payment rate may be adjusted by action of the Olmsted County Board of Commissioners.

2.77 The County may also seek recovery of costs through other methods allowed by Federal or State law.

SECTION 2.80 Authority to Modify or Remove Declaration of Chemical Investigation Site Public Health Nuisance

2.81 The designated Public Health authority may modify conditions of the declaration and order removal of the declaration of Chemical Investigation Site Public Health Nuisance.

2.82 Such modification or removal shall be only after the Public Health Authority has determined levels of contamination are sufficiently reduced through remediation to warrant modification or removal of the declaration. The Public Health Authority may rely on information from competent sources, including those supplied by the property owner and/or others such as state and local health, safety, and pollution control authorities to reach such decisions.

2.83 When the declaration is modified or removed the Public Health Authority shall forward that information to the County Recorder for addition to the property record if the Recorder has been notified as described above. Similarly, notice shall be provided to the motor vehicle or other license records agency and lien holders if a notice had previously been provided to them.

SECTION 2.90 Waste generated from cleaning up a clandestine drug lab.
Waste generated from chemical investigation site public health nuisances shall be treated, stored, transported, and disposed in accordance with applicable Minnesota Department of Health, Minnesota Pollution Control Agency, and Olmsted County rules and regulations for solid waste and for hazardous household and other hazardous wastes.

## ARTICLE III. EXCEPTIONS, APPEALS, and PENALTIES

SECTION 3.10 Exceptions, Appeals, and Penalties
Administration of this ordinance, including guidance for, challenges to, and penalties shall be according to the authorities provided in Minnesota Statute Chapter 145A, other applicable Minnesota law, and the Olmsted County Environmental Service's Administrative Ordinance.

SECTION 3.20 Severability And Savings Clause
If any section or portion of this ordinance shall be found unconstitutional or otherwise invalid or unenforceable by a court of competent jurisdiction, that finding shall not serve as an invalidation of, or affect the validity or enforceability of any other section or provision of this ordinance.

## ARTICLE IV. EFFECTIVE DATE

This ordinance shall be in full force and effect upon adoption pursuant to Minnesota law.

Dated this 23rd day of October, 2001.

OLMSTED COUNTY BOARD OF COMMISSIONERS

_____
Jean Michaels, Chairperson

ATTEST:

_____
Richard G. Devlin, Clerk-Administrator

K:\Environmental Hlth\drug labs\drug lab ord adopted 10-23-01.doc

# CITY of ALBUQUERQUE
## SIXTEENTH COUNCIL

COUNCIL BILL NO. O-04-29 ENACTMENT NO. 36-2004

SPONSORED BY: Craig Loy

*ORDINANCE*

AMENDING CHAPTER 11, ARTICLE 1, ROA 1994, PROVIDING FOR CLEANUP OF CLANDESTINE DRUG LABORATORES, NOTICE TO BUYERS AND OCCUPANTS, RESTITUTION AND PENALTIES.

BE IT ORDAINED BY THE COUNCIL, THE GOVERNING BODY OF THE CITY OF ALBUQUERQUE:

"SUBPART D: DRUG LABORATORY SITE REMEDIATION OF CONTAMINATION

Section 1. TITLE. This Ordinance shall be known and may be cited as the "Cleanup of Clandestine Drug Laboratory Sites Ordinance."

Section 2. FINDINGS AND INTENT. The City Council finds and states its intent as follows. Clandestine drug laboratory sites are increasing in number in Albuquerque and are a serious health threat to the community. Remediation of the residually contaminated portions of clandestine drug laboratory sites is essential to assure the health, safety and welfare of the community. Property owners must share the responsibility for the clandestine drug laboratory sites on their property by bearing the initial costs of remediation of such sites, subject to restitution as provided in this ordinance. This ordinance is timely and appropriate because current laws and city regulations are insufficient to address the aforementioned problems. The restrictions contained herein are neither over broad nor vague and are narrowly tailored to serve a substantial government interest.

Section 3. DEFINITIONS. In this Ordinance, unless the context otherwise requires:

(A) "Clandestine drug laboratory" means property on which methamphetamine, ecstasy, LSD or any other controlled substance is being

[+ Bracketed/Underscored Material + ] - New
[- Bracketed/Strikethrough Material - ] - Deletion

manufactured or on which there is an attempt to manufacture, or where a person is arrested for having on any property any chemicals or equipment used in manufacturing methamphetamine, ecstasy, LSD or any other controlled substance. In the case of a space rental mobile home or recreational vehicle park, clandestine drug laboratory means the mobile home or recreational vehicle in which methamphetamine, ecstasy, LSD or any other controlled substance is being manufactured or where a person is arrested for having in the mobile home or recreational vehicle any chemicals or equipment used in manufacturing methamphetamine, ecstasy, LSD or any other controlled substance. Clandestine drug laboratory shall include any place or area where chemicals or other waste materials used in clandestine drug laboratories have been located.

(B) "Controlled Substance" means any drug or substance or counterfeit substance listed in the Controlled Substances Act, NMSA 1978 Chapter 30, Article 31 or regulations adopted thereunder.

(C) "Drug Laboratory Site Remediation Firm" means a firm that is certified by the Albuquerque Police Department and the City Environmental Health Department and that performs remediation of residual contamination from the manufacture of methamphetamine, ecstasy, LSD or any other controlled substance or the storage of chemicals or equipment used in manufacturing methamphetamine, ecstasy, LSD or any other controlled substance.

(D) "Ecstasy" (3,4-methylenedioxy amphetamine) has the same meaning prescribed in NMSA 1978 Section 30-31-6 and includes any of the precursor chemicals, regulated chemicals, other substances or equipment used in the unlawful manufacture of Ecstasy and any derivatives thereof.

(E) "Gross contamination" means the chemicals, equipment and other items that are found in a clandestine drug laboratory and that are removed by a law enforcement officer or law enforcement agency.

(F) "Industrial or Environmental Hygienist Firm" means a firm that is certified by the Albuquerque Police Department and the City Environmental Health Department to conduct pre-remediation testing and post-remediation testing for the remediation of residual contamination from the manufacture of methamphetamine, ecstasy, LSD, or any other controlled substance or the storage of chemicals or

[+Bracketed/Underscored Material+] - New
[-Bracketed/Strikethrough Material-] - Deletion

equipment used in manufacturing methamphetamine, ecstasy, LSD or any other controlled substance.

(G) "Law Enforcement Officer" means any employee of a police or public safety department administered by the state or any political subdivision of the state where the employee is responsible for the prevention and detection of crime and the enforcement of the penal, traffic or highway laws of this state as defined in NMSA 1978 30-20A-2D, and specifically includes Albuquerque Police Department nuisance abatement inspectors.

(H) "LSD" (lysergic acid diethylamide) has the same meaning prescribed in NMSA 1978 Section 30-31-6 and includes any of the precursor chemicals, regulated chemicals, other substances or equipment used in the unlawful manufacture of LSD and any derivatives thereof.

(I) "Methamphetamine" has the same meaning prescribed in NMSA 1978 Section 30-31-7 and includes any of the precursor chemicals, regulated chemicals, other substances or equipment used in the unlawful manufacture of Methamphetamine and any derivatives thereof.

(J) "Owner" means any person, firm, corporation or other entity that owns, in whole or in part, the property subject to this ordinance.

(K) "Property" means real or personal property and includes the area within a structure and the area that surrounds a structure and that is within the land boundary or property lines of any of the following:

(a) Property that can be used for residential purposes or is occupied by people for any length of time for any purpose.

(b) Property that is governed by the Uniform Owner-Resident Relations Act, NMSA 1978 Sections 47-8-1 et seq., or the Mobile Home Park Act, NMSA 1978 Sections 47-10-2 et seq.

(c) A mobile home as defined in NMSA 1978 Section 47-10-2.

(d) A recreational vehicle as defined in NMSA 1978 Section 66-1-4.15 and for purposes of this ordinance, "recreational vehicle" shall also include a recreational travel trailer as defined in NMSA 1978 Section 66-1-4.15.

(e) a vehicle, as defined in Section 8-5-2-1 ROA 1994.

(L) "Residually contaminated portion of the property" means the structure or unit where gross contamination was removed and the area of any adjacent structure,

[+ Bracketed/Underscored Material + ] - New
[- Bracketed/Strikethrough Material - ] - Deletion

unit or land where visible evidence of residual contamination is observed by a law enforcement officer, including any of the following:

(a) If gross contamination is removed from a house, mobile home or recreational vehicle and the notice of removal is posted for the entire house, mobile home or recreational vehicle, then the entire house, mobile home or recreational vehicle, not just the room or rooms in which the gross contamination is found shall be deemed the residually contaminated portion of the property.

(b) If gross contamination is removed from a detached shed or garage, the other structures or property on the land are not affected and the notice of removal is posted only for the detached shed or garage, then the detached shed or garage shall be deemed the residually contaminated portion of the property.

(c) If gross contamination is removed from a hotel, motel room or apartment unit, the adjacent rooms are not affected and the notice of removal is posted only for the contaminated room or apartment unit, then the contaminated room or apartment unit shall be deemed the residually contaminated portion of the property.

(d) If gross contamination is removed from a vehicle, then the entire vehicle shall be deemed the residually contaminated portion of the property.

Section 4. DECLARATION OF PUBLIC NUISANCE. Upon identification by a law enforcement officer of a clandestine drug laboratory site, the property shall constitute a public nuisance until such time as the remediation required by this Ordinance is completed.

Section 5. CLANDESTINE DRUG LABRATORIES.

(A) PROCEDURES. If a law enforcement officer discovers a clandestine drug laboratory or arrests a person for having on any property chemicals or equipment used in manufacturing methamphetamine, ecstasy, or any other controlled substance or a derivative of methamphetamine, ecstasy, LSD or any other controlled substance, the law enforcement officer shall:

(1) At the time of the discovery or arrest, shall deliver a copy of the notice of removal pursuant to subsection (B) of this section to the owner of the property if the owner is on the site at the time of delivery, the on-site manager if the manager is on the site at the time of delivery or the on-site drop box if available. In the case of a tenant-owned unit in a space rental mobile home or recreational vehicle park, the officer shall deliver a copy of the notice of removal to the occupant of the unit if the occupant is on

[+ Bracketed/Underscored Material + ] - New
[-Bracketed/Strikethrough Material-] - Deletion

site at the time of delivery and to the on-site park landlord if the park landlord is on site at the time of delivery.

(2) If the owner or the owner of a space rental mobile home or recreational vehicle park or their agent for service is not personally provided a copy of the notice of removal under the procedures of subsection (A) (1) of this section, then within two City business days after the discovery or arrest, the law enforcement officer shall send the notice of removal by certified mail to the owner of the property and the owner's on-site manager or, in the case of a space rental mobile home or recreational vehicle park, to the owner of the mobile home or recreational vehicle, if applicable, and to the park landlord. These persons are deemed to have received the notice of removal five days after the notice is mailed.

(3) If the owner or the owner of a space rental mobile home or recreational vehicle park cannot be identified, the notice of removal may be posted on the property pursuant to subsection (A) (6) of this section.

(4) The notice of removal shall be sent to the following:

(a) The address of the owner and the owner of the mobile home or recreational vehicle park as shown on file with the county assessor.

(b) The Albuquerque Environmental Health Department.

(c) The Albuquerque Fire Department.

The law enforcement officer shall complete an affidavit of service for personal delivery of the notice of removal or posting notice on the property.

(5) After a law enforcement or other agency removes the gross contamination on the property, a law enforcement officer shall order the removal of all persons from the residually contaminated portion of the property or dwelling unit, if applicable, or, in the case of a space rental mobile home or recreational vehicle park, from the unit located on the property.

(6) After the law enforcement officer removes all persons pursuant to subsection (A) (5) of this section, the law enforcement officer shall affix the notice of removal in a conspicuous place on the property or, in the case of a space rental mobile home or recreational vehicle park, on the unit located on the property.

(7) The law enforcement officer shall cause a Certificate of Substandard Property to be filed with the Bernalillo County Assessor upon posting the notice of

[+ Bracketed/Underscored Material +] - New
[-Bracketed/Strikethrough Material-] - Deletion

removal. Such certificate shall include a legal description of the property and have attached to it the notice of removal.

(B) NOTICE. The notice of removal shall be in writing and shall contain all of the following:

(1) The following shall be printed in large bold type at the top and bottom of the notice: "Substandard Building. Do Not Enter. Unsafe to Occupy."

(2) A statement that it is unlawful for any person other than the owner, landlord, manager, law enforcement, an industrial or environmental hygienist firm and/or a drug laboratory site remediation firm to enter the residually contaminated portion of the property until the owner remediates the residually contaminated portion of the property, or in the case of a space rental mobile home or recreational vehicle park, the unit located on the property.

(3) A statement that a clandestine drug laboratory was seized or a person was arrested on the property for having chemicals or equipment used in the manufacturing of methamphetamine, ecstasy, LSD or any other controlled substance on the property.

(4) The date of the seizure or arrest.

(5) The address or location of the property, including the identification of any dwelling unit, room number, apartment number or vehicle identification number.

(6) The name of the law enforcement agency or other agency that seized the clandestine drug laboratory or made the arrest and the agency's contact telephone number.

(7) A statement that hazardous substances, toxic chemicals or other waste products may still be present on the property or, in the case of a space rental mobile home or recreational vehicle park, in the unit located on the property.

(8) A statement that the failure to remediate the residual contamination pursuant to the Cleanup of Clandestine Drug Laboratory Sites Ordinance is punishable by imprisonment up to 90 days and/or a fine up to $500.

(9) A statement that disturbing the notice of removal posted on the property is punishable by imprisonment up to 90 days and/or a fine up to $500.

(10) A statement that the owner of the property shall remediate the residually contaminated portion of the property in compliance with subsection (C) of this section.

[+ Bracketed/Underscored Material +] - New
[-Bracketed/Strikethrough Material-] - Deletion

(11) A statement that if an owner fails to provide any notice required by this section, the owner is subject to penalty and a buyer, tenant or customer may void a purchase contract, rental agreement or other agreement related to the property.

(C) REMEDIATION BY OWNER. The owner of the property shall remediate the residually contaminated portion of the property by retaining an industrial or environmental hygienist firm to pre-test the property to determine the extent of the contamination and the nature of the required remediation. When the industrial or environmental hygienist firm determines that remediation is required, the owner shall retain a drug laboratory site remediation firm to conduct the remediation. The industrial or environmental hygienist firm and the drug laboratory site remediation firm shall be separate and unaffiliated business entities. Both firms shall be approved and currently registered with the Albuquerque Police Department and the City Environmental Health Department during the time they participate in the remediation of residual contamination. The owner shall retain the industrial or environmental hygienist firm and the drug laboratory site remediation firm within 30 days of the day of delivery of personal service of the notice of removal or within 35 days of the date the notice of removal is mailed by certified mail or posted on the property. Remediation shall be completed in accordance with the standards for remediation of residual contamination adopted by the Albuquerque Police Department and the City Environmental Health Department within 60 days of the day of delivery of personal service of notice to the owner or within 65 days of the date notice is mailed by certified mail to the owner or for such other period of time that is approved in writing by the Albuquerque Police Department.

(D) REMEDIATION PROCEDURES. An industrial or environmental hygienist firm and the drug laboratory site remediation firm retained to remediate the residually contaminated portion of any property pursuant to this section shall comply with the best practices and standards for remediation of residual contamination adopted by the Albuquerque Police Department and the City Environmental Health Department. The industrial or environmental hygienist firm shall notify the owner whenever the firm determines that any structure requires remediation of contamination as required in this section. The owner shall send such notification of required remediation of contamination to Albuquerque Police Department, the City Environmental Health Department and the City's Chief Building Official. Within one

[+ Bracketed/Underscored Material + ] - New
[-Bracketed/Strikethrough Material-] - Deletion

City working day after the remediation is complete, the drug laboratory site remediation firm shall notify the Albuquerque Police Department, the City Environmental Health Department and the industrial or environmental hygienist firm that the property is ready for final inspection. After inspection by the industrial or environmental hygienist firm and approval by the Albuquerque Police Department and the City Environmental Health Department, the industrial or environmental hygienist firm shall issue a final clearance document certifying that remediation of the residually contaminated portion of the property was completed pursuant to the standards for remediation of residual contamination and shall deliver the certification document or send the document by certified mail to the owner. The owner shall provide a copy of the certification of completed remediation to each person and entity listed in subsection (A) (4) of this section, the City's Chief Building Official and the law enforcement agency that issued the notice under that subsection. After the final clearance document has been issued, both of the following apply:

(1) The owner, landlord, lien holder or manager of the property is not required to comply with subsection (G) of this section.

(2) Any person may use, enter, occupy, rent or sell the property.

It shall be the responsibility of the owner of the property to file with the County Assessor the document stating that the residually contaminated portion of the property has been remediated and neither the City, the industrial or environmental hygienist firm nor the drug laboratory site remediation firm shall be responsible for such filing or the costs associated with filing. The issuance of the document certifying that remediation of the residually contaminated portion of the property was completed pursuant to the standards for remediation of residual contamination shall be a prerequisite for a certificate of occupancy or any City required building inspection and shall not be in lieu of a certificate of occupancy or any City required building inspection.

(E) CONTAMINATED VEHICLES. If gross contamination is removed from a vehicle, the notice of removal required in subsection (B) of this section shall be sent by certified mail to the owner of record and lien holder of record, if any exists. Impounded vehicles containing residual contamination shall not be released to the owner or lien holder until the remediation has been completed and paid for by the owner or lien holder. Remediation shall be accomplished by following the same

[+Bracketed/Underscored Material+] - New
[-Bracketed/Strikethrough Material-] - Deletion

procedures as set forth in subsection (D) of this section. Remediation costs as defined in subsection (J) of this section shall be in addition to any other towing, storage, or other impoundment fees.

(F) RECORD RETENTION. The City Environmental Health Department shall maintain and make available on request all notices of removal and any documents that are created pursuant to subsection (D) of this section. A retention schedule for such documents shall be established by the City Clerk.

(G) NOTICE TO BUYERS AND OCCUPANTS. The following notice requirements apply until the remediation is complete as provided in subsection (D) of this section:

(1) Within five days after a buyer signs a contract to purchase property, the owner shall notify the buyer in writing that methamphetamine, ecstasy, or any other controlled substance was manufactured on such property or that an arrest, as described in subsection (A) of this section, was made. The buyer shall acknowledge receipt of the notice. A buyer may cancel the purchase contract within five days after receiving the notice without liability. If the owner does not comply with this paragraph, the buyer may void the purchase contract.

(2) Landlords and their agents shall provide written notice to all prospective tenants for dwelling units that the dwelling unit was the subject of a notice of removal, as described in subsections (A) and (B) of this section, that methamphetamine, ecstasy, or any other controlled substance was manufactured on the property or that an arrest, as described in subsection (A) of this section, was made. The tenant shall acknowledge receipt of the notice before taking possession of the property or before signing a rental agreement for the property. The notice shall be attached to the rental agreement. If the landlord or their agent does not comply with this paragraph, the tenant may void the rental agreement. For purposes of this paragraph, dwelling unit shall include but not be limited to mobile homes and recreational vehicles.

(3) Before a customer occupies a room that was the subject of the notice of removal, as described in subsection (A) of this section, the owner or manager shall notify the customer in writing the room was the subject of a notice of removal as described in subsection (A) and (B) of this section, that methamphetamine, ecstasy, LSD or any other controlled substance was manufactured in the room or that an arrest, as described in subsection (A) of this section, was made. The customer shall acknowledge

[+ Bracketed/Underscored Material + ] - New
[- Bracketed/Strikethrough Material - ] - Deletion

receipt of the notice before taking possession of the room and before signing a room rental agreement. If the owner or manager does not comply with this paragraph, the customer may void the agreement.

(4) Owners are required to notify all agents selling, leasing or renting property that is the subject of a notice of removal that such property is the subject of a notice of removal. When a sales, leasing or rental agent is notified that the property is the subject of a notice of removal, such agent shall notify in writing all prospective buyers, tenants or other occupants about the notice of removal and manufacture of methamphetamine, ecstasy, LSD or any other controlled substance on the property or that an arrest, as described in subsection (A) of this section, was made on the property. Notice shall be made in the same manner as required of the owner in this subsection (G).

(5) When a law enforcement officer has ordered the removal of all persons from property pursuant to section 5(A) (5), owners, landlords and their agents shall continue to be subject to the requirement to not permit people from occupying such property. Compliance with this subsection shall not eliminate the requirement that the property not be occupied.

(H) MOBILE HOME OR RECREATIONAL VEHICLE SPACE RENTAL PARKS: If a mobile home or recreational vehicle in a space rental park contains a clandestine drug laboratory, the landlord of the park, on receipt of a notice pursuant to subsection (A) this section, shall notify the owner and lienholder of record of the unit to remove the unit from the park within thirty days. This provision shall not apply when the owner of the contaminated mobile home or recreational vehicle is also the owner of the mobile home or recreational vehicle space rental park in which such contaminated mobile home or recreational vehicle is located. If the unit is not removed within thirty days, the landlord of the park shall remediate the contamination following the requirements set forth in subsections (C) and (D) of this section.

(I) RESTITUTION TO OWNER. A person who operates a clandestine drug laboratory and who is not the owner of the property shall pay restitution to the owner of the property for all costs that the owner incurred to remediate the property and in the instance of a mobile home or recreational vehicle, the cost incurred by the owner of a space rental park for moving and/or remediating such property.

[ + Bracketed/Underscored Material + ] - New
{ - Bracketed/Strikethrough Material - } - Deletion

(J) REMEDIATION BY CITY. If an owner of property, a vehicle owner, a vehicle lien holder or an owner of a mobile home or recreational vehicle space park, as described under subsection (H) of this section, fails to comply with the remediation of the residually contaminated property or portion of the property as required in this section, the City may remediate of the residually contaminated portion of the property or seek a court order requiring the owner to remediate in the manner required in this Section. If the City is unable to locate the owner within ten days after the issuance of the Certificate of Substandard Property, the City may proceed with remediation. If the City remediates the contamination, the owner shall pay to the City all costs related to such remediation. If the owner fails to pay the City for its costs of remediation, the City shall be entitled to file a lien against such property for the costs related to the remediation and bring legal action against the owner for such remediation costs. Remediation costs shall include, but are not limited to the expense for posting, physical security of the contaminated site, notification of affected people, businesses or any other entity, expenses related to the recovery of cost, laboratory fees, cleanup services, costs for testing for residual contamination, removal costs, and cost incurred for a industrial or environmental hygienist firm and a drug laboratory site remediation firm. When a contaminated vehicle is impounded, the vehicle shall not be released to the owner or a lien holder until remediation is completed and paid by the owner or lien holder and impoundment fees are paid by the owner or lien holder. Remediation costs for vehicles in which gross contamination is found shall include the costs for testing for residual contamination regardless of whether residual contamination is actually required to be remediated. Impoundment fees shall include those fees defined as impoundment charges in Section 8-5-2-1 ROA 1994. The City or its contractors may remove property as part of its remediation effort.

Section 6. PENALTIES.

(A) If an owner fails to provide any notice required by this section, the owner shall be subject to imprisonment up to 90 days and/or a fine of up to $500 and is liable for any harm resulting from the owner's failure to comply with the requirements of this section.

(B) A person who knowingly violates a notice of removal that is issued by a law enforcement officer under this ordinance is subject to imprisonment up to 90 days

[+ Bracketed/Underscored Material + ] - New
[-Bracketed/Strikethrough Material- ] - Deletion

and/or a fine of up to $500 for each day such person fails to comply with the notice of removal.

(C) All other violations of this ordinance shall be subject to the penalty provisions of Section 1-1-99 ROA 1994."

Section 7. Severability Clause. If any section, paragraph, word or phrase of this ordinance is for any reason held to be invalid or unenforceable by any court of competent jurisdiction, such decision shall not affect the validity of the remaining provisions of this ordinance. The Council hereby declares that it would have passed this ordinance and each section, paragraph, sentence, clause, word or phrase thereof irrespective of any provision being declared unconstitutional or otherwise invalid.

Section 8. Compilation. Section 1 of this ordinance shall be incorporated in and made part of the Revised Ordinances of Albuquerque, New Mexico.

Section 9. Effective Date: This ordinance shall take effect five days after publication by title and general summary.

[+ Bracketed/Underscored Material +] - New
[- Bracketed/Strikethrough Material -] - Deletion

X:\SHARE\Legislation\Sixteen\o-29fin.doc

PASSED AND ADOPTED THIS 21st DAY OF JUNE, 2004
BY A VOTE OF: 8 FOR 0 AGAINST.

Yes: 8

Excused: Mayer

Michael Cadigan, President
City Council

APPROVED THIS 24th DAY OF June, 2004

Bill No. O-04-29

Martin J. Chavez, Mayor
City of Albuquerque

ATTEST:

City Clerk

[+Bracketed/Underscored Material+] - New
[-Bracketed/Strikethrough Material-] - Deletion

Lane County, OR, Lane Code §§ 5.700 to 5.990 (2004)

Updated 3/31/04

Lane Code
CHAPTER 5 CONTENTS

ADMINISTRATIVE ENFORCEMENT
5.005 Definitions.
5.010 Establishment of Administrative Enforcement Procedures.
5.015 Organization.
5.017 Establishment of Administrative Civil Penalties.
5.020 Abatement by County; Costs; Waiver; Lien.
5.030 Hearing.
5.035 Classification of Violations.
5.040 Classification of Failure to Comply.
5.055 Employee Misconduct.

PROHIBITED NOISE
5.600 Findings and Purpose.
5.605 Definitions.
5.610 Sound Measurement.
5.615 Failure to Comply.
5.620 Exceptions.
5.625 Variances.
5.630 Subchapter Additional to Other Law.
5.635 Initiation of Administrative Enforcement Proceeding by Private Party.

NUISANCE
5.700 Purpose.
5.705 Exemptions.
5.710 Definitions.
5.720 Nuisances Vegetation.
5.725 Nuisance Storage of Tires.
5.730 Nuisance Vehicle Storage.
5.740 Accumulation, Collection or Storage of Solid Waste or Waste.
5.745 An Abandoned, Discarded, or Unattended Icebox, Refrigerator, or Other Container with a Compartment.
5.747 Illicit Discharge.
5.750 Properties Declared "Unfit for Use" Due to Illegal Drug Manufacturing Contamination.
5.990 Failure to Comply.

regulation shall supersede the provisions of this subchapter and may be enforced, to the fullest extent allowed by law, by Lane County. *(Revised by Ordinance No. 4-89, Effective 5.11.89; 5-99, 7.28.99)*

**5.635 Initiation of Administrative Enforcement Proceeding by Private Party.**

(1) A person other than the Manager or designee may commence an administrative enforcement proceeding for any failure to comply with LC 5.600 et seq., by filing a complaint with the Manager.

(2) The filing of the complaint is subject to LC 5.010, and must contain at least:

(a) The name and address of the person bringing the action, and the name and address of the defendant.

(b) A statement or designation of the failure to comply that can be readily understood by a person making a reasonable effort to do so and the date, time and place at which this is alleged to have occurred.

(c) A certificate signed by the complainant stating that the complainant believes that the named defendant committed the failure to comply as specifically identified in the complaint and that the complainant has reasonable grounds for that belief. A certificate conforming to this section shall be deemed equivalent of a sworn complaint. Complaints filed under this section are subject to the penalties provided in ORS 153.990 for false certification.

(3) Upon the filing of a complaint under this section, the Manager shall cause a summons to be delivered to the defendant.

(4) The Manager may, acting in his or her sole discretion, amend a complaint filed under the provisions of this section.

(5) The hearings officer shall dismiss a complaint filed under this section upon motion from either the Manager or the defendant if:

(a) The Manager has brought or intends to bring a proceeding against the defendant named in the complaint by reason of the same conduct alleged, or

(b) Another citizen initiated complaint has been brought against the defendant named in the complaint by reason of the same conduct alleged. *(Revised by Ordinance No. 4-89, Effective 5.11.89; 5-99, 7.28.99; 1-00, 4.12.00)*

## NUISANCE

**5.700 Purpose.**

The purpose of LC 5.700 through 5.750 is to regulate the accumulation of waste, solid waste, tires, inoperable vehicles and vegetation on public and private property. The remedies provided for failure to comply with LC 5.700 through 5.750 shall not be exclusive and shall be in addition to other remedies provided by law. The County expressly reserves the right to seek abatement through separate civil proceedings in addition to and not in lieu of administrative enforcement under this chapter. Nothing contained herein shall preclude civil actions alleging failure to comply with the provisions of this chapter constitute negligence per se. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-00, 4.12.00; 7-02, 6.14.02)*

**5.705 Exemptions.**

Unless specifically provided otherwise, LC 5.700 through 5.750 does not apply to:

(1) Disposal sites operated in compliance with regulations promulgated by the Environmental Quality Commission, Department of Environmental Quality, or other ordinances or regulations of the County.

(2) Outdoor storage of inoperable or unregistered vehicles when the land has a zoning district which permits or conditionally permits outdoor storage of inoperable or used vehicles and the vehicles are stored in accordance with applicable provisions.

(3) Property located within the corporate limits of incorporated cities. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-00, 4.12.00; 7-02, 6.14.02)*

**5.710 Definitions.**

For the purposes of LC 5.700 through 5.750, the following words and phrases shall mean:

Director. The Director of Public Works, the Director's designee, or the Manager of the Land Management Division, or the Manager's designee.

Certificate of Fitness. A certificate issued for a particular property by the Oregon Health Division following a satisfactory site characterization by a licensed drug laboratory decontamination contractor, sampling and testing by an independent, third party approved by the Oregon Health Division, and any necessary contamination reduction of the property by such licensed contractor. The certificate authorizes removal of the property from the State Building Codes Division's "Unfit for Use" listing and allows reuse of the property.

Illicit Discharge. Any discharge to the storm water system that is not composed entirely of storm water, or as determined by EPA Storm Water Phase II Final Rule, with the following exceptions:

(a) Discharges from NPDES permitted industrial sources;
(b) Fire fighting activities;
(c) Water line flushing;
(d) Landscape irrigation;
(e) Diverted stream flows;
(f) Rising ground water;
(g) Uncontaminated ground water infiltration;
(h) Uncontaminated pumped ground water;
(i) Discharges from potable water sources;
(j) Foundation drains;
(k) Air conditioning condensation;
(l) Irrigation water;
(m) Springs;
(n) Water from crawl space pumps;
(o) Footing drains;
(p) Lawn watering;
(q) Individual residential car washing;
(r) Flows from riparian habitats and wetlands;
(s) De-chlorinated swimming pool discharges;
(t) Street wash water.

Inoperable Vehicle. A vehicle which:

(a) Has been left on private property for more than 30 days; and

(b) Has broken or missing window(s); or broken or missing windshield; or a missing wheel(s), or a missing tire(s); or lacks an engine or will not run; or lacks a transmission or the transmission is inoperable; and

(c) The vehicle is over three years old.

(d) For purposes of this section, a showing that the vehicle(s) in question is unlicensed and, if operated on a public highway of this state, would be in violation of one or more of the following provisions: ORS 815.020, 815.100, 815.125, 815.155, 815.160, 815.170, 815.180, 815.195, 815.235, 815.245 through 815.260, 815.270, and 815.295 constitutes a rebuttable presumption that it is inoperable.

Motor Vehicle. A vehicle that is self-propelled or designed for self-propulsion.

Noxious Vegetation: Includes:

(a) Weeds more than 10 inches high.

(b) Grass more than 10 inches high unless that vegetation is an agricultural crop and does not create a fire hazard or traffic hazard.

(c) Poison Oak or Poison Ivy.

(d) Tansy Ragwort.

(e) Blackberry bushes that extend into a public thoroughfare or across a property line.

(f) Thistle.

Nuisance. Includes, but is not limited to any annoying, unpleasant, or obnoxious condition or practice causing an unreasonable threat to the public health, safety and welfare and defined as a nuisance in LC 5.720 through 5.750.

Person. Includes individuals, corporations, associations, firms, partnerships and joint stock companies.

Person in Charge of Property. An owner, agent, occupant, lessee, tenant, contract purchaser, or other responsible person having possession or control of the property or the supervision of a construction project on the property.

Responsible Person. As defined in LC 5.005(7), and includes:

(a) The person in charge of property on which the nuisance exists or which abuts a public way where a nuisance exists.

(b) The person who causes the nuisance to come into or continue in existence.

Putrescible Material. Organic material that decomposes and gives rise to foul or offensive odors, or foul or offensive by-products.

Solid Waste. Solid Waste includes all putrescible and non-putrescible waste, including, but not limited to, garbage, rubbish, refuse, ashes, waste paper and cardboard, grass clipping, composts, sewer sludge, residential, commercial, and industrial appliances, equipment and furniture, discarded or inoperable vehicles, vehicle parts or vehicle tires, manure, vegetable or animal solid and semisolid waste and dead animals. The term Solid Waste does not include:

(a) Materials used for fertilizer or for other productive purposes on land in the growing and harvesting of crops or the raising of fowl or animals. This exception does not apply to the keeping of animals on land which has been zoned for residential nonagricultural purposes.

(b) Septic tank and cesspool pumping or chemical toilet waste;

(c) Reusable beverage containers as defined in ORS 459A.725.

(d) Source separated principal recyclable materials as defined in ORS Chapter 459 and the Rules promulgated thereunder, which have been purchased or exchanged for fair market value.

Storm Water Sewer System, Storm Water System. For purposes of this chapter, a drain and collection system, including roads, ditches, channels, pipes, and culverts, designed and/or operated by Lane County for the sole purpose of collecting rain and other naturally occurring precipitation or storm water runoff. The Storm water sewer system is not a combined sewer system and does not include conveyance of any wastewater.

Storm Water, Storm Water Runoff. Water that washes off or runs off the land as a result of naturally occurring precipitation, such as a snow or rainstorm, which does not infiltrate into the soil.

Tire. The band of material used on the circumference of a wheel which forms the tread that comes in contact with the surface of the road.

Unfit for Use. A designation by the Oregon Health Division that means that the property has been found to be, or there are reasonable grounds to believe that the property was, the site of illegal drug manufacture and may be contaminated with hazardous chemicals or substances and therefore is not fit to use until appropriate site assessment and any necessary contamination reduction procedures have been performed by a licensed drug laboratory decontamination contractor.

Unregistered Vehicle. A vehicle without a license plate or with an expired license plate.

Vegetation. Plant life, including but not limited to, trees, shrubs, flowers, weeds and grass.

Vehicle. Any device in, upon, or by which any person or property is or may be transported, or drawn upon a public highway, and includes vehicles that are propelled or powered by any means, but does not include a device propelled by human power.

Waste. Waste is useless unwanted or discarded materials. The fact that materials, which would otherwise come within the definition of Solid Waste or Waste, may from time-to-time have value and thus be utilized, shall not remove them from the definition. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00; 7-02, 6.14.02; 1-04, 4.9.04)*

**5.720 Nuisances Vegetation.**

(1) Any vegetation that creates the following conditions on any public or private property shall constitute a nuisance and no person responsible shall cause or permit such conditions to exist:

(a) Vegetation that is a hazard to pedestrian or vehicular use of any sidewalk or street by obstructing passage or vision. The hazards include, but are not limited to:

(i) Vegetation that encroaches upon or overhangs a pedestrian way or adjacent parking strip lower than nine feet or encroaches upon or overhangs a street lower than 15 feet.

(ii) Vegetation which obstructs motorist or pedestrian view of traffic signs and signals, street lights and name signs, or other safety fixtures or markings placed in the public way.

(b) Vegetation that is an obstruction of access to a use of any public facilities placed within the public way.

(c) Noxious vegetation on public or private property in those areas within Urban Growth Boundaries of incorporated cities or within developed and committed areas designated Community or zoned RR-5, RR-2, RR-1 or RA in the Lane County Rural Comprehensive Plan on August 1, 1987. No owner or person in charge of such property may allow noxious vegetation to be on the property or encroach into the right-of-way of a public thoroughfare abutting on the property.

(2) A failure to comply with this section shall be cause for a responsible person to be subject to the administrative enforcement procedures set forth in this chapter. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00; 7-02, 6.14.02)*

**5.725 Nuisance Storage of Tires.**

(1) The following things, practices or conditions shall constitute a nuisance and no person responsible shall cause or permit such condition to exist:

(a) The storage of 4 or more used tires on private or public property in those areas within Urban Growth Boundaries of incorporated cities or within developed

and committed areas designated Community or zoned RR-5, RR-2, RR-1 or RA in the Lane County Rural Comprehensive Plan on August 1, 1987, unless the tires are used for agricultural or landscaping purposes.

(b) The storage of 10 or more used tires on private or public property not described in 5.725(1)(a) above, unless the tires are used for agricultural or landscaping purposes.

(c) Notwithstanding the above, the storage of tires on private property is permitted if the property owner is conducting a legally operated business that normally deals in tires, or if the tires are completely enclosed within a building and do not constitute a fire hazard or health hazard.

(2) Failure to comply with this section shall be cause for a responsible person to be subject to the administrative civil penalty procedures set forth in this chapter. The imposition of a monetary penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00)*

**5.730 Nuisance Vehicle Storage.**

(1) The following things, practices or conditions shall constitute a nuisance and no person responsible shall cause or permit such condition to exist:

(a) Storing or permitting to be stored in excess of 90 days within any consecutive 12 month period an unregistered or inoperable vehicle or portion thereof, or two or more unregistered or inoperable vehicles at any one time on any private property in those areas within Urban Growth Boundaries of incorporated cities or within developed and committed areas designated Community or zoned RR-5, RR-2, RR-1 or RA in the Lane County Rural Comprehensive Plan on August 1, 1987, unless the vehicle is completely enclosed within a building, or is not visible from any public way and is located more than 200 feet from any property line, or unless it is stored on the premises of a business enterprise dealing in used vehicles lawfully conducted within the County.

(b) Storing or permitting the storing of more than three inoperable vehicles upon private property within the County and not described in 5.730(1)(a) above, unless the vehicle is completely enclosed within a building, or is not visible from any public way and is located more than 200 ft. from any property line, or unless it is stored on the premises in connection with a lawfully conducted business.

(2) A failure to comply with this section shall be cause for a responsible person to be subject to the administrative enforcement procedures set forth in this chapter. The imposition of a penalty.does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00)*

**5.740 Accumulation, Collection or Storage of Solid Waste or Waste.**

(1) Any accumulation, collection or storage of solid waste or waste, shall constitute a nuisance and no person responsible shall cause or permit such condition to exist unless the person responsible is licensed by lawful authority to operate a business specifically for those purposes.

(2) A failure to comply with this section shall be cause for a responsible person to be subject to the administrative enforcement procedures set forth in this chapter. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00)*

**5.745 An Abandoned, Discarded, or Unattended Icebox, Refrigerator, or Other Container with a Compartment.**

(1) Any abandoned, discarded or unattended icebox, refrigerator or other container with a compartment of more than one and one-half cubic feet capacity and an

airtight door or lid which locks or fastens automatically when closed and which cannot be easily opened from the inside shall constitute a nuisance and no person responsible shall cause or permit such condition to exist.

(2) A failure to comply with this section shall be cause for a responsible person to be subject to the administrative enforcement procedures set forth in this chapter. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 11-87, Effective 9.17.87; 1-93, 4.16.93; 1-00, 4.12.00)*

**5.747 Illicit Discharge.**

For the purpose of this section, the following requirements shall apply within the Eugene and Springfield Urban Growth Boundaries as defined at LC 10.600-10 and 10.600-20, and outside the respective incorporated city limits.

(1) No responsible person shall allow an illicit discharge from his or her premises to flow out on or under a public way.

(2) No responsible person shall place or cause to be placed a substance which is harmful to or has a tendency to clog the County storm water system or permit such substance in the control of such person to enter the County storm water system.

(3) No person shall discharge, or cause to be discharged, any substance other than storm water, except discharges authorized by written approval of the Oregon Department of Environmental Quality (DEQ) or the Director. The Director may deny approval to discharge into the County storm water system if the discharge poses a threat to health, safety, public welfare, or the environment, or is otherwise prohibited by law. The Director may withdraw approval to discharge if the Director determines that a discharge poses a threat to health, safety, public welfare, or the environment, or is otherwise prohibited by law. Any person lawfully discharging pursuant to a National Pollutant Discharge Elimination System permit as of March 10, 2004 shall be deemed to have received written approval from the Director. Such approval may be withdrawn if the Director determined that the discharge poses a threat to health, safety, public welfare, of the environment, or is otherwise prohibited by law.

(4) Every establishment or place where the substances prohibited in subsection (2) above is or may be produced is hereby required to install such necessary catch basin traps or other devices for the purpose of preventing such substance from entering the County storm water system. Where the Director reasonably believes that any such substance may be produced, the Director may require any responsible person to furnish to the County plans prepared by a registered engineer showing the proposed method of elimination. Such device shall be approved only if tests and subsequent engineering data establish that a desirable standard of removal is produced.

(5) No responsible person shall allow storm water to flow out on or under a public way in a manner that creates a traffic or other hazard for those lawfully using the public way or that creates a hazard to improvements within the public way.

(6) A failure to comply with this section shall be cause for a responsible person to be subject to enforcement procedures set forth in this chapter. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 1-04, Effective 9.4.04)*

**5.750 Properties Declared "Unfit for Use" Due to Illegal Drug Manufacturing Contamination.**

(1) Property placed on the Oregon Health Division "unfit for use list" pursuant to ORS 453.879 because it has been used for the manufacture of illegal drugs shall be considered a nuisance 90 days after it has been listed and shall remain a nuisance until

such time as it is issued a "Certificate of Fitness" by the Oregon Health Division, and no responsible person shall cause or permit such a condition to exist.

(2) A failure to comply with this section shall be cause for a responsible person to be subject to the administrative enforcement procedures set forth in this chapter. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. *(Revised by Ordinance No. 7-02, Effective 6.14.02)*

**5.990 Failure to Comply.**

(1) A person who fails to comply with any provision of Lane Code shall be subject to administrative enforcement pursuant to LC Chapter 5, except for those provisions which are specified to be violations, or which specify incarceration as a penalty. A notice of failure to comply may be signed, issued and served by any designated agent of the County.

(2) A person who fails to comply with LC 5.600 et seq. is subject to a monetary penalty of not less than $500 for a first failure to comply and $1,000 for each subsequent failure to comply committed within one year of the first occurrence. However, the hearings officer may suspend up to $400 of the monetary penalty to be paid for a first offense upon receiving from the person who has failed to comply a signed, verified statement that said person agrees not to cause any further failure to comply with LC 5.600 et. seq. within the following year, and further stating that if it is determined that said person should so fail to comply, the suspended portion of the monetary penalty amount be then due and payable, in addition to any amounts to be due for the subsequent failures to comply. Persons who fail to comply with LC 5.600 et seq. are also subject to the administrative civil penalty procedures set forth in this chapter. Any enforcement proceedings allowed herein may be commenced by the Manager. The imposition of a penalty does not relieve a responsible person of the duty to abate the nuisance. For purposes of this subsection a separate failure to comply will be deemed to have occurred for every occurrence that is more than 15 minutes from the previous failure to comply.

(4) Dog owners shall renew the dog license before it becomes delinquent. A late fee of $10 will be charged if the license is renewed after it has become delinquent.

(5) A license tag issued to the dog shall be attached securely to a collar or harness on the dog for which it is issued. If a license is lost, the owner shall obtain a duplicate license tag upon satisfactory proof of loss and payment of the required fee.

(6) A person who violates this section commits a Class B Infraction. *(Revised by Ordinance No. 8-81, Effective 6.3.81; 2-82, 4.9.82; 21-83, 11.29.83; 11-87, 9.17.87; 6-89, 5.24.89; 1-93, 4.16.93; 5-99, 7.28.99; 1-00, 4.12.00; 4-00, 5.10.00)*

# State Clandestine Laboratory Cleanup and Remediation Statutes/Regulations/Guidelines/Guidance Documents

**Please note that a number of states have put together guidelines or guidance documents for the cleanup and remediation of methamphetamine laboratories. We have defined certain documents as guidelines based on the content provided. Documents we are considering guidelines are those that contain detailed scientific sampling information and remediation standards for methamphetamine. We have considered certain documents as "guidance documents" because they tend to be less detailed in nature and do not address a remediation standard for methamphetamine.

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.
Research current through August 20, 2004.

## State Clandestine Laboratory Cleanup and Remediation Statutes/Regulations/Guidelines/Guidance Documents

| State | Statutes | Regulations | Guidelines | Guidance Documents |
|---|---|---|---|---|
| Alabama | | | | |
| Alaska | ALASKA STAT. §§ 46.03.500 to -599 (Michie 2003). | | Alaska Dep't of Envtl. Conservation, *Guidance and Limits for Cleanup of Illegal Drug-Manufacturing Sites at* http://www.state.ak.us/dec/spar/perp/docs/druglab_guidance.pdf (last visited October 5, 2004). | |
| Arizona | ARIZ. REV. STAT. ANN. §§ 12-990, 12-1000 to 1001, 32-101, 32-112, 32-141 (West 2004). | ARIZ. ADMIN. CODE R.4-30-103, -270, -272, -305 (2004). | | |
| Arkansas | ARK. CODE ANN. § 20-7-132 (Michie 2003) | | Arkansas Department of Health, *Clandestine Methamphetamine Laboratory Cleanup Guidelines, at* http://www.healthyarkansas.com/pdf/adh_methguidelines_2004.pdf (last visited August 26, 2004). | |
| California | | | | |
| Colorado | H.B. 1182, 64TH Gen. Assem., 2d Reg. Sess. (Co. 2004). | | Colorado Department of Public Health and Environment, *Cleanup of Clandestine Methamphetamine Labs Guidance Document, at* http://www.cdphe.state.co.us/hm/methlab.pdf (last visited August 27, 2004). | |
| Connecticut | | | | |
| Delaware | | | | |
| District of Columbia | | | | |
| Florida | | | | |
| Georgia | | | | |
| Hawaii | | | | |

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.
Research current through August 20, 2004.

## State Clandestine Laboratory Cleanup and Remediation Statutes/Regulations/Guidelines/Guidance Documents

| State | Statutes | Regulations | Guidelines | Guidance Documents |
|---|---|---|---|---|
| Idaho | | | | |
| Illinois | | | | Illinois Department of Public Health, Environmental Health, *Fact Sheet: Methamphetamine Laboratories and Cleanup, at* http://www.idph.state.il.us/envhealth/factsheets/meth-labs.htm (last visited September 27, 2004).<br><br>Illinois Department of Public Health, Environmental Health, *Fact Sheet: Guidelines for Cleaning Up Former Methamphetamine Labs, at* http://www.idph.state.il.us/envhealth/factsheets/meth-cleanup.htm (last visited September 27, 2004). |
| Indiana | | | | |
| Iowa | IOWA CODE ANN. §§ 124C.1 to 124C.7 (West 2004). | | | |
| Kansas | | | | Kansas Department of Health and Environment, Division of Environment, *Cleaning Up Former Methamphetamine Labs, at* http://www.kdhe.state.ks.us/methlabs/mi_cleanup.html (last visited September 27, 2004). |
| Kentucky | | | | |
| Louisiana | | | | |
| Maine | | | | |
| Maryland | | | | |
| Massachusetts | | | | |
| Michigan | | | | |
| Minnesota | | | Minnesota Dep't of Health, *Clandestine Drug Labs General Cleanup Guidelines, at* http://www.health.state.mn.us/divs/eh/meth/lab/cleanup0903.pdf (last visited September 1, 2004). | |
| Mississippi | | | | |

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.
Research current through August 20, 2004.

## State Clandestine Laboratory Cleanup and Remediation Statutes/Regulations/Guidelines/Guidance Documents

| State | Statutes | Regulations | Guidelines | Guidance Documents |
|---|---|---|---|---|
| Missouri | MO. ANN. STAT. § 640.040 (West 2004). | | | Missouri Department of Health and Senior Services, Section for Environmental Public Health, *Guidelines for Cleaning up Former Methamphetamine Labs*, at http://www.dhss.state.mo.us/ResourceMaterial/meth.pdf (last visited September 27, 2004). |
| Montana | | | | |
| Nebraska | | | | |
| Nevada | | | | |
| New Hampshire | | | | |
| New Jersey | | | | |
| New Mexico | | | | |
| New York | | | | |
| North Carolina | S.B. 1054, 2003 Gen. Assem., Sess. 2004 (N.C. 2004). | | | |
| North Dakota | | | | North Dakota Dep't of Health, Div. of Waste Management, *Best Management Practices for Cleanups at Methamphetamine Labs*, at http://www.health.state.nd.us/ndhd/environ/wm/pdf/mo_drugs.pdf (last visited April 16, 2004). |
| Ohio | | | | |
| Oklahoma | | | | Oklahoma Dep't of Environmental Quality, *Guidelines for Cleaning Up Former Methamphetamine Labs*, at http://www.deq.state.ok.us/LPDnew/MethLabs/meth.htm (last visited September 27, 2004). |
| Oregon | OR. REV. STAT. §§ 453.855 to -995 (2003). | OR. ADMIN. R. §§ 333-040-0010 to -0230, 918-010-0000 to -0025 (2004). | | |
| Pennsylvania | | | | |

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.
Research current through August 20, 2004.

## State Clandestine Laboratory Cleanup and Remediation Statutes/Regulations/Guidelines/Guidance Documents

| State | Statutes | Regulations | Guidelines | Guidance Documents |
|---|---|---|---|---|
| Rhode Island | | | | |
| South Carolina | | | | |
| South Dakota | | | | |
| Tennessee | 2004 Tenn. Pub. Acts Ch. 855. | TENN. COMP. R. & REGS. tit. 1200, ch.1-19 (2004). | Tenn. Dept. of Evn't & Conservation, *Reasonable, Appropriate, Protective Cleanup Response and Documentation Guidelines for Properties Quarantined due to Clandestine Laboratory Activities, at* http://www.state.tn.us/environment/dsf/meth/ (last visited September 13, 2004). | |
| Texas | | | | |
| Utah | UTAH CODE ANN. §§ 19-6-901 to 19-6-906, 26A-1-121 (2004). | | | |
| Vermont | | | | |
| Virginia | | | | |
| Washington | WASH. REV. CODE ANN. §§ 64.44.005 to -901, 69.50.511, 70.105D.070 (West 2004). | WASH. ADMIN. CODE §§ 246-205-001 to -131, 246-205-510 to -990, 296-62-3040 to -30465 (2004). | Washington State Dep't of Health, *Guidelines for Environmental Sampling at Illegal Drug Manufacturing Sites, at* http://www.doh.wa.gov/ehp/ts/CDL/cdl-_envir-sampling.pdf (last visited September 27, 2004). | |
| West Virginia | | | | |
| Wisconsin | | | | Wisconsin Div. of Public Health, Bureau of Environmental Health, *Cleaning Up Hazardous Chemicals at Methamphetamine Laboratories, at* http://www.dhfs.state.wi.us/eh/ChemFS/fs/MethClnUp.htm (last visited September 27, 2004). |
| Wyoming | | | | |

© 2004 THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS. 700 North Fairfax Street, Suite 550, Alexandria, VA 22314. (703) 836-6100.
Research current through August 20, 2004.