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

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JULY 26, 2005

Serial No. 109–101

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

24–946 PDF WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
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FIGHTING METH IN AMERICA'S HEARTLAND: ASSESSING THE IMPACT ON LOCAL LAW ENFORCEMENT AND CHILD WELFARE AGENCIES

TUESDAY, JULY 26, 2005

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 2:08 p.m., in room 2154, Rayburn House Office Building, Hon. Mark E. Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder, McHenry, Mica, Gutknecht, Foxx, Cummings, and Watson.

Also present: Representatives Osborne and Cooper.

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

Mr. SOUDER. The subcommittee will come to order. Thank you all and thank you for coming. Today we continue our subcommittee's work on the problem of meth trafficking and abuse—a problem that is ravaging the entire Nation and putting a severe strain on law enforcement agencies and child welfare programs, particularly at the State and local levels.

Displayed on the video screens are a series of photographs that capture a young woman's 10-year progression and downward spiral resulting from meth addiction. These graphic photos demonstrate the real-life impact of meth abuse.

[The information referred to follows:]

The Faces of Methamphetamine

Mr. SOUDER. This is actually the ninth hearing on meth held by the subcommittee since 2001. In places as diverse as Indiana, Arkansas, Hawaii and Minnesota, I have heard gripping testimony about how this drug has devastated lives and families. But I have also learned about the many positive ways that communities have fought back, targeting the meth cooks and dealers, trying to get addicts into treatment, and working to educate young people about the risks of meth abuse.

Meth is one of the most powerful and dangerous drugs available, and 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. The drug is highly addictive and has multiple side effects, including psychotic behavior, physical deterioration and brain damage. Death by overdose is a significant risk.

Most meth comes from the so-called "super labs" in California and northern Mexico, and Congress currently is exploring ways to address that growing problem. However, it is frequently the smaller, clandestine or "clan" labs that generate so much damage and misery for local communities. The amount of meth that is created at these smaller labs is relatively small, yet the impact the labs have on the community is staggering, due to the environmental damage and health risks that they create.

The National Association of Counties [NACo] recently published two surveys which detail the impact that meth is having on law enforcement agencies and child welfare services. The surveys, entitled, "The Criminal Effect of Meth on Communities," and "The Impact of Meth on Children: Out of Home Placement," surveyed hundreds of counties nationwide on the effects of meth. The NACo law enforcement agency survey reported that nearly 60 percent of responding counties stated that meth was their largest drug problem.

The surveys provide further evidence of how the meth epidemic is quickly spreading across the Nation, from rural to suburban and urban areas. In the NACo survey directed toward law enforcement agencies, the information on meth-related arrests and meth cases overall was staggering. Of the 500 responding counties in the past year, 67 percent reported increases in meth-related arrests. Counties in the southwest reported particularly disturbing results, with 76 reporting such increases. Over half of the agencies surveyed stated that at least 1 in 5 jail inmates are serving meth-related sentences.

The surveys also demonstrate that children are increasingly becoming the primary victims of meth abuse. The surveys found that 40 percent of child welfare agencies reported an increase in "out of home placements because of meth in the past year." This abuse unfortunately includes physical and mental trauma, and even sexual abuse; 69 percent of county social service agencies have indicated that they have had to provide additional, specialized training for their welfare system workers and had to develop new and special protocols for workers to address the special needs of children affected by meth. Community Health and Human Services, as well as child welfare services, such foster care, are being overwhelmed as a result of meth.

Officials at every level of government, Federal, State and local, must take effective, coordinated action to address the meth epidemic. U.S. Attorney General Alberto Gonzales recently declared that, "in terms of damage to children and to our society, meth is now the most dangerous drug in America." As Members of Congress, we need to take a careful look to see what additional legislation and resources are needed.

First, what forms of direct assistance, particularly in the expensive realm of environmental cleanup, should the Federal Government provide to local agencies when dealing with meth lab busts and their aftermath? Second, what kind of specialized training can and should the Federal Government provide to State and local agencies, both in law enforcement and the child welfare service areas?

And third, what are the "best practices" for dealing with children found at meth labs sites?

In Indiana, just in the last few days, as most of the Members of Congress had been saying, there have been multiple major arrests, events in western Indiana, eastern Illinois. One of these guys got into an anhydrous ammonia tank—a 1,000-gallon leak that they had to evacuate many blocks of town and then eventually the whole area, a problem that we faced in a number of rural areas in my district and across Indiana.

We had a recreational vehicle plant that had a rumor that they had the problem so they did a quick drug test and found a third of the people at the plant where the average income is over $72,000, hardly a low-income area, that one-third were high at work that day, most on meth but also including marijuana and cocaine.

A big story over the weekend was about one of these workers who, he and his wife, both were very professional, had been destroyed as they started with marijuana, moved to meth at this plant and had their lives wrecked. And this story is becoming far too frequent in community after community, and is starting to hit our major metro areas.

As we heard in St. Paul, MN, two big cities where the data—by next year, the national agencies will be reporting the data coming in from these counties and all of a sudden, this meth will go from 8 percent to much higher in these cities and the data is behind.

It is one of our biggest collection problems that we have when we look at this committee and as we do our oversight hearings. Our data is often 2003 drug data and the issue is moving so fast in the category of meth, it is flat-out wrong right now.

At today's hearing, we will hear from the Federal, State and local agencies that fight on the "front lines" against the meth epidemic. We welcome Mr. Scott Burns, Deputy Director for State and Local Affairs from the Office of National Drug Control Policy; Mr. Joseph Rannazzisi, Deputy Chief of the Office of Enforcement at the Drug Enforcement Administration; and Ms. Laura Birkmeyer, Assistant U.S. Attorney in San Diego, CA and chairperson of the National Alliance for Drug Endangered Children.

On the second panel we will hear from Dr. Nancy Young, Director of the National Center on Substance Abuse and Child Welfare, which is funded by the Federal Substance Abuse and Mental

Health Services Administration [SAMHSA], and Director of Children and Family Futures; Ms. Valerie Brown of the National Association of Counties; Ms. Freida Baker, deputy director of Family and Children's Services at the Alabama Department of Human Resources; Chief Deputy Phil Byers from the Rutherford County, NC Sheriff's Office; Ms. Sylvia Deporto, deputy director of Riverside County Children's Services in California; Ms. Betsy Dunn, investigator and peer supervisor from the Tennessee Department of Children's Services, Child Protective Services Division; Chief Don Owens of the Titusville, PA, Police Department; and Sheriff Mark Shook from the Watauga County, NC Sheriff's Department.

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

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

Opening Statement
Chairman Mark Souder

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

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

July 26, 2005

Good afternoon, 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 and child welfare programs, particularly at the state and local levels.

Displayed on the video screens are a series of photographs that capture a young woman's ten year progression and downward spiral resulting from methamphetamine addiction. These graphic photos demonstrate the real-life impact of meth abuse.

This is actually the ninth hearing focusing on meth held by the Subcommittee since 2001. In places as diverse as Indiana, Arkansas, Hawaii and Minnesota, I have heard gripping testimony about how this drug has devastated lives and families. But I have also learned about the many positive ways that communities have fought back, targeting the meth cooks and dealers, trying to get addicts into treatment, and working to educate young people about the risks of meth abuse.

Meth is one of the most powerful and dangerous drugs available, and 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. The drug is highly addictive and has multiple side effects, including psychotic behavior, physical deterioration, and brain damage. Death by overdose is a significant risk.

Most meth comes from the so-called "superlabs" in California and northern Mexico, and Congress is currently exploring ways to address that growing problem. However, it is frequently the smaller, clandestine or "clan" labs that generate so much damage and misery for local communities. The amount of meth that is created at these smaller labs is relatively small, yet the impact the labs have on the community is staggering, due to the environmental damage and health risks that they create.

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The surveys provide further evidence of how the meth epidemic is quickly spreading across the nation, from rural to suburban and urban areas. In the NACo survey directed towards law

[1] National Association of Counties. Surveys: "The Impact of Meth on Children: Out of Home Placement" and "The Criminal Effect of Meth on Communities". July 5, 2005.

enforcement agencies, the information on meth related arrests and meth cases overall was staggering. Of the 500 responding counties in the past year, 67% reported increases in meth related arrests. Counties in the Southwest reported particularly disturbing results, with 76% reporting such increases. Over half of the agencies surveyed stated that at least 1 in 5 jail inmates are serving methamphetamine related sentences.

The surveys also demonstrate that children are increasingly becoming the primary victims of meth abuse. The surveys found that 40% of child welfare agencies reported an increase in "out of home placements because of meth in the past year."[2] This abuse unfortunately includes physical and mental trauma, and even sexual abuse. 69% of county social service agencies have indicated that they have had to provide additional, specialized training for their welfare system workers and have had to develop new and special protocols for workers to address the special needs of the children affected by methamphetamine.[3] Community health and human services, as well as child welfare services such as foster-care, are being overwhelmed as a result of meth.

Officials at every level of government – federal, state and local – must take effective, coordinated action to address the meth epidemic. U.S. Attorney General Alberto Gonzales recently declared that, "in terms of damage to children and to our society, meth is now the most dangerous drug in America."[4] As Members of Congress, we need to take a careful look to see what additional legislation and resources are needed.

First, what forms of direct assistance – particularly in the expensive realm of environmental cleanup – should the federal government provide to local agencies when dealing with meth lab busts and their aftermath? Second, what kind of specialized training can and should the federal government provide to state and local agencies, both in the law enforcement and the child welfare services areas? And third, what are the "best practices" for dealing with children found at meth labs sites?

At today's hearing, we will hear from the federal, state and local agencies that fight on the "front lines" against the meth epidemic. We welcome Mr. Scott Burns, Deputy Director for State and Local Affairs from the Office of National Drug Control Policy; Mr. Joseph Rannazzisi, Deputy Chief of the Office of Enforcement at the Drug Enforcement Administration; and Ms. Laura Birkmeyer, Assistant U.S. Attorney in San Diego, California and Chairperson of the National Alliance for Drug Endangered Children.

On the second panel we will hear from Dr. Nancy Young, Director of the National Center on Substance Abuse and Child Welfare (which is funded by the federal Substance Abuse and Mental Health Services Administration, or SAMHSA) and Director of Children and Family Futures; Ms. Valerie Brown of the National Association of Counties; Ms. Freida Baker, Deputy Director of Family and Children's Services at the Alabama Department of Human Resources; Chief Deputy Phil Byers from the Rutherford County (North Carolina) Sheriff's Office; Ms. Sylvia Deporto, Deputy Director of Riverside County Children's Services in California; Ms. Betsy Dunn, Investigator and Peer Supervisor from the Tennessee Department of Children's Services, Child Protective Services Division; Chief Don Owens of the Titusville (Pennsylvania) Police Department; and Sheriff Mark Shook from the Watauga County (North Carolina) Sheriff's Department.

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

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[2] Ibid.
[3] Ibid.
[4] Prepared Remarks of Attorney General Alberto Gonzales at the National District Attorneys Association Meeting, Portland, ME. July 18, 2005. www.usdoj.gov.

Mr. SOUDER. I yield next to Mr. McHenry.

Mr. MCHENRY. Thank you, Mr. Chairman, and thank you for bringing attention to this important issue. Today we are discussing fighting methamphetamine and trying to bring attention to this matter. I think it is named appropriately "Fighting Meth in America's Heartland," because that is mainly where it is occurring in small and rural communities across this Nation, and so it's becoming an epidemic in places like my district in western North Carolina, and we are struggling to battle this issue.

I certainly appreciate Chief Deputy Sheriff Philip Byers and his wife, Sheila, for being here today. They will be part of our second panel. I look forward to introducing them at that time.

We have two expert panels today to talk about the staggering effects that meths have on our Nation. I think it's most important that we hear from our sheriffs' offices especially, and our State-run child service programs, because they have the unique challenge of dealing with this in small communities across America where this epidemic is occurring.

In 2004, over 3,357 children nationally were found to be connected with seized meth labs. This is an issue of severe concern for this Congress and for this committee. The problem is growing, but it is not a faceless problem, as our witnesses will testify today. The debilitating mental and physical effects of this drug, the production process, and the way it touches everyone, especially in rural communities, are not being overlooked.

In North Carolina alone, Medicaid costs, in part, have increased due to the rise of children that have been taken out of homes with meth labs. Beyond that, the medical expenses that society will bear, that our governments will fund, and we as taxpayers will fund, because of this meth addiction that our folks are dealing with. I think it's important that we promote awareness about this spreading problem that we protect our children and provide resources to those on the front lines so that we can take on this key area of concern.

I would like to welcome all of our witnesses today. Thank you for taking time to be here before Congress. It will be a unique process for you. Some of you have been here before, but for those that have not, it should be definitely a learning experience for both of us.

Thanks so much.

Mr. SOUDER. Ms. Foxx, do you have an opening statement?

Ms. FOXX. Thank you, Mr. Chairman. I would like to thank both the chairman and the ranking member of the subcommittee for holding this hearing and for their continued effort to fight the dire methamphetamines problem in this country. I want to thank the members of both panels for the work you do in your communities in collaborating with Congress today in this constructive dialog on how to best address this problem nationwide.

I am honored to have one of my constituents and community leaders here today as a member of the second panel. Sheriff Mark Shook of Watauga County, my home county, has truly become an expert and leader in this area through his outstanding work over the past several years. As a former patrol officer and detective, Sheriff Shook has over 20 years experience from the law enforcement side before being elected Watauga County sheriff 3 years ago.

At that point, he wrapped his arms around the meth problem and tackled it at full force. He understands the curse that meth has been on our community and has done a terrific job in attacking the problem from all angles. He has been extremely effective in educating our community about meth, and my first knowledge about this problem came from a workshop that he held in our community, attended by over 100 people. I have known Mark his entire life, and we share a passion for the beauty of the mountains of northwestern North Carolina.

Methamphetamine production and abuse have been a scourge on the beautiful mountain area that Mark and I care deeply about. Sheriff Shook and I have teamed up to minimize and eliminate the problem. With his leadership and tireless efforts, we have made great strides.

I am honored and proud to have Sheriff Shook here today to share his success with Congress, and I hope his story can be a benefit to the subcommittee and other communities that are afflicted with meth abuse.

The challenge meth abuse poses is strong, serious and immediate, and so, too, must be our response. The outstanding job Sheriff Shook has done at the local level must be duplicated at the Federal level if we are to eradicate meth from our communities.

I look forward to receiving the testimony of our panelists and hope we can use the feedback to create a firm legislative response to the meth problem.

Thank you again, Mr. Chairman.

Mr. SOUDER. Mr. Gutknecht.

Mr. GUTKNECHT. Just very briefly, Mr. Chairman. Again, thanks for this hearing. More importantly, thank you for taking the subcommittee around the country to hear from folks from all areas of our Nation. This is a huge and a growing problem. We learned, for example, in the Twin Cities, that there is a growing sense among law enforcement that no longer is this a drug which is just being produced in rural communities, that more and more of it is actually coming in from Mexico, across our borders, which raises even more interesting questions that we at the Federal level need to address. So, again, thank you for this hearing and thank you for your dogged pursuit of this particular issue.

I yield back.

Mr. SOUDER. Thank you, I would now like to recognize a nonmember of this subcommittee, Mr. Cooper, who wants to introduce a Tennessee witness. Tennessee has been one of the hardest-hit States. Your delegation has been great, including the gentleman with us today in helping us to fight meth. I recognize you for the purpose of your introduction.

Mr. COOPER. Thank you, Mr. Chairman. I really appreciate your leadership on this issue because I know of no greater scourge our rural area faces than meth. Tennessee has been hard hit. We are about second worst State in America, and that is not a distinction that any of us wants to hear.

I am particularly proud that Betsy Dunn will be joining us on the second panel, because she is the model of what a Child Protective Services worker should be. She has been at it for 16 years and we know it is a high turnover in her profession. She is serving in

one of the toughest areas of the country. Our hometown of Cookesville is beautiful, a university town and wonderful, but all around Cookesville, our areas have been very hard hit by meth.

Many of us have read horror stories by the famous author Stephen King, but I think Betsy can tell us scarier stories than anything that Stephen King has written about, because her stories are real and they are affecting our kids every day in large numbers. Our State went ahead and the State legislature took pseudoephedrine off the pharmacy shelves. I hope that our adjoining States and all the States in the country will consider steps to do that, to do anything they possibly can, anything to alleviate the scourge.

But we are very proud of Betsy and her pioneering work over the years. You make us proud, Betsy.

Thank you.

Mr. SOUDER. Thank you. I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions to the hearing record and that any answers to written questions by the witnesses also be included in the hearing record. Without objection, it is so ordered.

I ask unanimous consent that all exhibits, documents and all other materials referred to by Members 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.

Our first panel is composed of Mr. Scott Burns, Deputy Director for State and Local Affairs, Office of National Drug Control Policy; Mr. Joseph Rannazzisi, Deputy Chief, Office of Enforcement of DEA; Ms. Laura Birkmeyer, U.S. Assistant Attorney, San Diego and chairperson for the National Alliance for Endangered Children.

Would each of you stand, as an oversight committee it's our standard practice to ask our witnesses to testify under oath.

[Witnesses sworn.]

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

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

STATEMENTS OF SCOTT BURNS, DEPUTY DIRECTOR, STATE AND LOCAL AFFAIRS, OFFICE OF NATIONAL DRUG CONTROL POLICY; JOSEPH RANNAZZISI, DEPUTY CHIEF, OFFICE OF ENFORCEMENT OF DEA; AND LAURA BIRKMEYER, ASSISTANT U.S. ATTORNEY, SAN DIEGO, AND CHAIRPERSON, NATIONAL ALLIANCE FOR ENDANGERED CHILDREN

STATEMENT OF HON. SCOTT BURNS

Mr. BURNS. Thank you, Chairman Souder, and distinguished members of the subcommittee for inviting me to discuss our national efforts against meth. I am particularly honored, Mr. Chairman, to be here with Mr. Rannazzisi and Ms. Birkmeyer, both renowned experts, not only in this country, but worldwide. Mr. Rannazzisi, as you know, is not only a respected DEA agent, but a lawyer and a pharmacist.

Ms. Birkmeyer, a fellow road warrior, we see each other crossing the country, is not only an assistant U.S. Attorney who has spent

years in the courtroom prosecuting methamphetamine cases, but she is truly a voice and a champion for children in this country on these issues. So I am honored.

I am also honored to be here with my brothers and sisters in law enforcement from rural America. As you know, Mr. Chairman, before coming here to work for the President and the drug czar, I spent 16 years as a prosecutor in a small town. I learned about the destructive aspects and nature of methamphetamine firsthand. I worked with police officers who were put at risk by having to respond to, enter and sit on meth labs. I worked with city councilmen and city commissioners and others to try to figure out a way to pay for the overtime while we waited for a DEA chemist or work crews to come in. I met with innocent neighbors who lived near houses who were turned in meth labs. I have learned of children whose parents were found to be under the influence of meth and suffered neglect as a result.

As you know, Mr. Chairman, this is a bad drug. The toxic waste, 6 or 7 pounds of waste associated with each pound of methamphetamine is produced, children poisoned and toxicity levels at the lab, burns from explosion, I see Congressman Cooper here, I know that we were out in Tennessee at the burn unit and the children and those suffering from meth explosions, the violence associated with this drug and the costs to incarcerate and clean up. It affects and destroys individual lives, as we know, of families and communities.

So the national drug strategy has to be balanced. As you know, our priorities are prevention and treatment, and also a marked destruction, dismantling drug trafficking organizations. We believe the strategy, with your help and your leadership, has yielded success through the monitoring the future survey and the household survey, those measures that we look to determine whether or not we are doing any good—17 percent reduction over the last 3 years. Our strategy to reduce drug use in America has not, however, been focused on one illicit drug at the expense of another, but seeks to reduce all illicit drug use in this country. The increase in treatments for meth over the past few years, especially in the western and midwestern States, illustrates the devastating impact of the drug on many adults.

The good news, however, is that the surveys show that methamphetamine use among teens is down 25 percent over the last 3 years. Hopefully, the message is reaching them that we can buildupon those reductions with respect toward children.

I will be brief, because I want to take questions, but I want to just basically outline some of the efforts in combating the meth problem on a Federal level, the Drug Endangered Children Program, and Ms. Birkmeyer will talk about that in depth.

The NAMSDL, or National Alliance of Model State Drug Laws, Sherry Green and others that are in her office putting on training in summits and town halls across the country. The HIDTA program, more initiatives in the High Intensity Drug Trafficking Areas Program, are focused on methamphetamine than any other singular drug. You talked about the NACo survey and the perception or determination that methamphetamine was a No. 1 problem.

The HIDTAs are charged with determining the threat in their area and responding appropriately and more initiatives to target

methamphetamine than any other single drug. The national methamphetamine chemical drug initiative, again one that Ms. Birkmeyer oversees in the HIDTA program, that brings together the best and the brightest of law enforcement officers across this country to talk about trends and ways to make the problem smaller.

The administration has kept level the request for funding for cleanup in Federal law enforcement, as Mr. Rannazzisi will talk about, has done a phenomenal job, especially of shutting down the flow of pseudoephedrine from Canada into the United States, over a 90 percent reduction in interdiction. The methamphetamine advertisements or PSAs that you, Mr. Chairman, and others were so helpful in bringing to fruition, will be coming out.

I chair the Synthetic Action Plan that brought together my office, as well as the Department of Justice, and just about everybody in the intergovernmental world in Washington to sit down and try to come up with recommendations to bring to the Congress with respect to how to make this problem smaller.

I personally thank you for your leadership and for your courage, to take on these issues, as was mentioned, you are not only here in Washington but out in the field. I have been to Indiana as you know, twice to try to assist and just about every other State in the country, talking about this issue.

I ask that my full statement be made part of the official record and I look forward to your questions, thank you.

Mr. SOUDER. Thank you.

[The prepared statement of Mr. Burns follows:]

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

Statement by Scott M. 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
Chairman Mark E. Souder, 109th Congress

July 26, 2005

Chairman Souder, Ranking Member Cummings, and distinguished Members of the Subcommittee: thank you for the opportunity to appear before you today to discuss our national efforts against methamphetamine.

The issue of methamphetamine 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 Iron County, Utah where methamphetamine use, sales, and production were a problem. In 16 years as a prosecutor in a rural county, I learned about the destructive nature of methamphetamine first-hand by working frequently with police officers who were put at risk by having to respond to, enter, and "sit on" methamphetamine labs; by meeting with innocent neighbors who lived near houses turned into methamphetamine labs; and by discovering children whose parents were found to be under the influence of methamphetamine, and suffered neglect as a result.

Methamphetamine is undeniably a uniquely destructive drug. I am grateful for the opportunity to play a role in addressing the methamphetamine problem in my current position as co-chair of the Administration's government-wide coordinating committee for policy regarding methamphetamine and other synthetic drugs—the Synthetic Drugs Interagency Working Group. In my testimony, I hope to accomplish two things: one, to provide an update on our fight against methamphetamine and two, describe the way ahead in sustaining a coordinated response to methamphetamine use, production and trafficking.

As the committee is aware, the President's *National Drug Control Strategy* is a balanced approach to reducing drug use by focusing on three national priorities: Prevention, Treatment, and Market Disruption. The goal is to reduce illicit drug use in America by at least five percent each year, both in the youth-only category, and for Americans as a whole. As the committee is also aware, we are pleased that we have exceeded this goal with respect to young people: total drug use among eighth, tenth, and twelfth graders is down 17 percent over the last three years.

Our strategy to reduce drug use in America is not focused on one illicit drug at the expense of another, but seeks to reduce all illicit drug use. However, officials at ONDCP, the Department of Health and Human Services, and the Department of Justice realize that methamphetamine, illicitly used prescription drugs, and club drugs – collectively referred to as synthetic drugs – pose a unique challenge, and constitute an emerging problem. For that reason, the Administration began new work on a comprehensive plan to attack the methamphetamine

problem. The plan, called the *National Synthetic Drugs Action Plan*, was published in October, 2004, and released by the Administration along with Members of Congress at the site of a small toxic lab in rural Missouri. That document is what guides our national efforts to curb methamphetamine use and production.

As the Administration moves forward to implement and refine the various recommendations within the *Action Plan*, we have begun to see age and geographic trends. Our drug abuse survey instruments suggest different use patterns by various segments of the population. The increase in treatment entries for methamphetamine over the past two years, especially in Western and Mid-Western states, illustrates the devastating impact of the drug on many adults. However, we are pleased methamphetamine use among teens is down 25 percent over the past three years.

After the implementation of a major operation in cooperation with our Canadian counterparts to target rogue chemical companies and distribution channels to choke off the supply of precursor chemicals to domestic "superlabs" (methamphetamine labs with a production capacity exceeding 10 pounds within a 24-hour period), the number of superlabs detected by law enforcement fell from 142 in 2002 and 132 in 2003 to just 55 in 2004 and seizures of pseudoephedrine at our northern border, another focus of that operation, are now down by 92 percent. Additionally, rural drug use in 2003, the last year for which we have data, was down 54 percent (this is for all illicit drugs, but methamphetamine is known to be a particular problem in rural areas).

The conclusions we draw from these preliminary data are not that our efforts to address the methamphetamine problem can now be relaxed, but rather, that by continuing to implement our comprehensive and balanced effort, we can see further reductions in both methamphetamine use and production.

The methamphetamine production problem exists on two levels: the large-scale level, at which superlabs (increasingly operating outside of our borders) receive bulk smuggled pseudoephedrine and convert it, together with other precursor chemicals, into the drug; and the small-scale level, at which small to medium labs create the drug using pseudoephedrine products purchased or diverted at the retail or wholesale level.

In targeting the large-scale methamphetamine production described above, the Department of Justice, primarily acting through the Drug Enforcement Administration, is the lead with respect to Mexico – a major producer or transshipment point for much of the methamphetamine entering America.

- DEA officials recently negotiated an arrangement with top officials from Hong Kong, Panama and Mexico. Additionally, various information-sharing arrangements have been negotiated with the countries that supply the largest amounts of otherwise-legal chemicals used in making methamphetamine: China and India.

- DEA has provided training, equipment, and other assistance to Mexican law enforcement so Mexico can more effectively target methamphetamine labs.

- The Administration has successfully worked with online sites, such as eBay, to reduce or eliminate the uncontrolled online sales of chemicals used to make methamphetamine.

- DEA's Operation Northern Star, coupled with Canada's implementation of its laws through regulations effective in January 2003, is continuing demonstrate significant success. A critical objective in 2002 and 2003 was to reduce the illicit flow of methamphetamine precursors into Canada and then down in the United States. After Operation Northern Star began, seizures of those chemicals slowed dramatically.

- At the same time, Department of Homeland Security agencies and DEA have stepped up enforcement efforts on the Southwest Border and have seized record amounts of methamphetamine at the Southwest Border. Through DEA's leadership, we have launched other operations designed to stifle the illegal international flow of chemicals used to make methamphetamine. For example, Project Prism, initiated six months after President Bush took office, has 37 participating countries and five international organizations. Since March 2004, Project Prism has used pre-export notifications to monitor 420 shipments of ephedrine totaling 330,000 kilograms, 1,600 shipments of pseudoephedrine totaling 3,800,000 kilograms, 772 shipments of pharmaceutical preparations containing ephedrine or pseudoephedrine, 10 shipments of phenyl-2-propanone involving 18,000 kilograms, and one shipment of 3,4-methylenedioxyphenyl-2-propanone totaling 4,000 kilograms. Approximately 5,163 kilograms of 60 milligram tablets of pseudoephedrine have been seized in the United States, Mexico, and Panama under Project Prism, having a capability to yield 3,098 kilograms of methamphetamine at a 60 percent conversion rate.

One of the most critical aspects of our efforts over the next several months will be to continue the process of negotiation and information-sharing with our partner nations whose businesses legitimately supply pseudoephedrine products to the United States, Mexico, Canada and other countries. In short, the more information that DEA and other Administration officials have about international pseudoephedrine shipments, the better we can ensure that these shipments are not diverted to methamphetamine labs for nefarious purposes.

Meanwhile, the Administration continues to provide assistance to state and local partners working hard to address their local methamphetamine problem through efforts related to treatment, prevention and market disruption.

- The "Drug Endangered Children" program was created during the President's first term, and exists with Federal support to help children adversely affected by methamphetamine-using adults. Twenty-five states now have DEC programs, and the Administration continues to work with interested states to expand this program.

- The Administration requested $167.7 million for methamphetamine enforcement, interdiction, and cleanup from FY 2002 through FY 2006.

- Administration officials have met with representatives from companies which manufacture otherwise-legal products used in the production of methamphetamine,

encouraging them to voluntarily restrict their sales. Several large companies, including Pfizer, Rite-Aid, McNeil and Target, voluntarily adopted restrictions.

- The Administration is in the process of revising the Guidelines for the Cleanup of Clandestine Drug Laboratories, 2005 edition, the so-called "Red Book" which includes voluntary standards, lessons learned, and best practices for methamphetamine laboratory cleanup as well as for the removal of source chemicals found at methamphetamine and other clandestine laboratory sites by federal, state, or local law enforcement and environmental officials.

- The President's FY 2006 drug control budget is up 2.2 percent with increases in areas vital to the methamphetamine effort – treatment programs, domestic law enforcement, interdiction, and international efforts. The portion of the drug control budget dealing with treatment is up 4.5 percent; drug enforcement is up 2.1 percent; interdiction is up 8.2 percent, and international efforts are up 21.4 percent.

We have also continued, at unprecedented levels, to stopping drug use before it starts and to heal America's drug users. Methamphetamine addiction can be treated, but in some cases, a longer time period and in-patient treatment is required to successfully enter recovery. The Administration has proposed increased support for state and local drug treatment across America over the last several years.

- The FY 2006 budget requests $150 million – an increase of $50.8 million for Access to Recovery, a voucher-based treatment grant program which can support individuals seeking treatment for methamphetamine addiction.

- The budget also requests a total of $70 million – an increase of more than $30 million – for the Drug Courts Program, which almost entirely goes to support state and local drug court services, many or all of which are able to monitor persons before the court for possession of methamphetamine.

- The budget requests $25.4 million – a $15.4 million increase – for Student Drug Testing, to ensure that already-seen reductions in methamphetamine use among teens (25 percent in three years) continues as a trend.

- HHS is supporting several research and data-related efforts to better understand the best way to treat people suffering from abuse of and addiction to methamphetamine and other synthetic drugs – and make that information available to state and local partners.

We believe that the principles in the President's *National Drug Control Strategy* are important in any consideration of addressing a drug threat: to balance prevention, treatment, and market disruption. In the case of methamphetamine, ensuring that would-be methamphetamine cooks are unable to gain access to the ingredients they need to make the drug is of critical importance. Some control over consumer access to pseudoephedrine products can help to do that, though such control must also always be balanced against legitimate consumer access to these products. A number of States have approached this challenge in different ways, taking into account their

individual law enforcement and consumer access needs. Early data indicate that several States which have done this through individual legislative and regulatory initiatives appear to have seen real reductions in the number of methamphetamine labs in their states. It is essential to deny methamphetamine cooks the ability to gather the ingredients they need while balancing the need of law abiding citizens to be able to access these commonly used cold products.

Thank you again for the opportunity to testify on this important topic, and I welcome any questions the Subcommittee may have regarding methamphetamine and the Administration's efforts to reduce its use, production and trafficking.

Mr. SOUDER. Mr. Rannazzisi.

STATEMENT OF JOHN RANNAZZISI

Mr. RANNAZZISI. Thank you, sir. Chairman Souder and distinguished members of the House Government Reform Committee, Subcommittee on Criminal Justice, Drug Policy, and Human Resources, on behalf of the Drug Enforcement Administration's Administrator, Karen P. Tandy, I appreciate your invitation to testify here today regarding DEA's effort to combat methamphetamine trafficking and abuse across the United States.

I just want to say that I am both honored and humbled to sit here at the table with Ms. Birkmeyer and Mr. Burns. They have given us outstanding—nothing short of outstanding support in our fight against drug abuse, and they should be recognized for that.

Today, few communities in the United States have not felt the crushing impact of methamphetamine, which goes far beyond the actual trafficking and abuse of this drug. The DEA is well aware that combating this drug requires a multifaceted approach to law enforcement.

In addition to our domestic and international enforcement efforts, the DEA is battling this drug through the efforts of our office of training, hazardous waste disposal program and victimless witness assistance program. Training is vital to ensure that officers conducting laboratory investigations are provided with safe and efficient procedures and equipment which allows them to work in these dangerous environments.

Since 1998, with funding originally received to the community-oriented policing program [COPS], and then through direct annual appropriations, the DEA offers a strong training program for our State and local counterparts. Each of our training courses exceeds OSHA-mandated minimum safety requirements and is provided at no cost to qualified local law enforcement officers.

Since 1998, we have trained over 8,600 State and local law enforcement personnel plus an additional 1,900 DEA employees to conduct clandestine laboratory investigations, dismantle seized labs and to protect the public from methamphetamine toxic waste. As part of this training, approximately $19 million in meth lab personal protective equipment has been provided to State and local law enforcement officers. The DEA has also conducted training for our foreign counterparts and has also provided awareness training for our U.S. military in Afghanistan.

Today our hazardous waste program, with the assistance of COPS, supports and funds the cleanup of a majority of the laboratories seized in the United States. This program promotes the safety of law enforcement personnel and the public by using qualified companies with specialized training and equipment to remove hazardous wastes seized at clandestine drug labs. The average cost of the cleanup during the initial contract was approximately $17,000 and currently the average cost is approximately $2,000.

To further reduce the cost of clandestine lab cleanups, in fiscal year 2004 we join the Kentucky State Police to join a pilot clandestine lab container program in Kentucky. This program has streamlined the laboratory cleanup process and has resulted in the reduction of operational costs, the length of time officers must remain on

the lab site and overtime costs to law enforcement agencies. The current average cleanup lab time cost in this project is approximately $350 per site.

More than any other controlled substance, methamphetamine trafficking endangers children to the exposure of drug abuse, neglect, physical and sexual abuse, toxic chemicals, hazardous waste, fire and explosions.

A key goal of the DEA victim and witness program is to provide assistance to victims of methamphetamine, particularly drug-endangered children. Each of our field divisions has a victim-witness coordinator to insure that all endangered children are identified and that the child's immediate safety is addressed at the scene by appropriate child welfare and health service providers.

Assistance has also been provided to vulnerable adults, individuals of domestic violence and customers and employees of businesses, such as motels and hotels such as where methamphetamine has been produced and seized.

We also provide training on drug-endangered children to Federal, State and local law enforcement and to national State and local victims organizations. In order to provide the public with current information on methamphetamine and drug-endangered children, the DEA participates in numerous local, State and national conferences and exhibits.

In conclusion, the DEA is attacking the methamphetamine epidemic on all available fronts. In addition to our domestic and international enforcement efforts, we provide vital laboratory training equipment to law enforcement officers from across the country. Our hazardous waste program, with the assistance of grants to State and local law enforcement, supports and funds the cleanup of a majority of the clandestine laboratories seized in the United States.

Over the years, this program has become more efficient, and we have engaged in efforts to further streamline this process and reduce the cleanup costs. Through the victim-witness assistance program, we are providing assistance to methamphetamine victims.

Chairman Souder, distinguished members of the subcommittee, 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.

[The prepared statement of Mr. Rannazzisi follows:]

Statement of

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

Before the

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

July 26, 2005

"Fighting Meth in America's Heartland:
Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

Chairman Souder, and distinguished members of the House Government Reform Committee, Subcommittee on Criminal Justice, Drug Policy and Human Resources, on behalf of the Drug Enforcement Administration's (DEA) Administrator, Karen Tandy, I appreciate your invitation to testify today regarding the DEA's efforts to combat methamphetamine trafficking and abuse across the United States.

Overview

Today, few communities in the United States have not felt the crushing impact of methamphetamine, which goes far beyond the actual trafficking and abuse of the drug and the numerous other crimes and acts of violence it creates. The devastating consequences of methamphetamine are felt across the country by individuals, governmental agencies, businesses and communities of all sizes. Americans are waging a daily battle against this drug.

The DEA is well aware that combating this drug requires a multi-faceted approach by law enforcement. In addition to our domestic and international enforcement efforts, the DEA is battling this drug through the efforts of our Office of Training, Hazardous Waste Disposal Program and Victim Witness Assistance Program.

The DEA's Office of Training has shared our clandestine laboratory expertise by training thousands of our state and local partners from all the over country, as well as our international counterparts. Through our Hazardous Waste Disposal Program, we provide cleanup assistance to law enforcement agencies across the country, as they battle this drug. The DEA's Victim Witness Assistance Program helps provide assistance for children and others, who in so many instances have been exposed to this drug and the toxic chemicals used in its manufacture.

DEA's Clandestine Laboratory Training

The increasing number of clandestine laboratory seizures nationwide has spurred the demand from state and local law enforcement agencies for increased training on the processing

of laboratory sites. Our Office of Training has found that as the methamphetamine epidemic has relentlessly spread eastward, requests for training have been received from states that have historically not had to deal with the issue of clandestine laboratories. This training is vital to ensure that officers conducting laboratory investigations are provided with safe and efficient procedures for the processing of methamphetamine labs.

Since 1998, with funding originally received through the Community Oriented Policing (COPS) program and then through direct annual appropriations, the DEA has offered a strong training program for our state and local counterparts. 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. Each of our training courses exceeds the Occupational Safety Health Administration (OSHA)-mandated minimum safety requirements and is provided at no cost to qualified state and local law enforcement officers. The cost incurred by the DEA per student for the basic certification course offered to state and local officers is approximately $4,360. This total amount includes approximately $2,200 worth of personal protective equipment that is provided to each officer.

The basic certification provides instruction and hands on training that enables graduates to operate safely within the confines of the contaminated environment of a drug laboratory. The students also become well-versed in the use of personal protective equipment, and respiratory protection. The advanced "site-safety" course enables graduates to serve as the required "site-safety officer" at the lab site, and also to re-certify other officers in the field. We also provide tactical training, which address issues regarding the nature of the equipment and methods unique to clandestine drug operations. The Clandestine Laboratory Training Unit has also added a block of instruction dealing with drug endangered children. This block of instruction is provided to ensure that the proper steps are taken when a child/victim is discovered within the confines of a toxic drug laboratory. This training is designed to complement existing departmental policies regarding endangered children.

The DEA has trained over 8,600 State and local law enforcement personnel (plus 1,900 DEA employees) since 1998 to conduct clandestine laboratory investigations, dismantle seized labs and protect the public from methamphetamine lab toxic waste. As part of this training, approximately $19 million in methamphetamine lab personal protective equipment has been provided to state and local law enforcement officers. 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. We also provide 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 Office of Training also conducts a number of courses off-site each year to meet regional training demands and provides annual recertification training as required by OSHA. The Clandestine Laboratory Training Unit has also provided training to fire departments, tactical units, and other federal agencies such as the Bureau of Alcohol, Tobacco, Firearms and Explosives.

In 2003, the Clandestine Laboratory Training Unit entered into a partnership the National Guard Counter-drug Training Center. The DEA's training supports 10 to 12 Basic Certification courses per year that are sponsored by the National Guard and we send an Agent/Instructor and a

Forensic Chemist to provide instruction at these courses. This training is for state and local officers only, and is conducted at various sites within the United States. By the completion of FY 2005, the Office of Training will have supported 27 National Guard Certification Courses.

The DEA also provides training to our foreign counterparts in all facets of clandestine drug laboratory investigations. Despite not falling under the OSHA requirements, most of our foreign counterparts are trained to OSHA standards. Since June 2003, we have provided training regarding lab investigations and prosecution to our Mexican counterparts on five occasions. This training was provided to over 200 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). The Unit has also supported basic certification courses in Lithuania, the Philippines, Indonesia, and awareness training for the U.S. Military in Afghanistan.

Importantly, the exchange of information does not stop upon the completion of the training course. Our instructors continue to provide assistance and expertise to our own Special Agents, as well as to state and local law enforcement, prosecutors, industry professionals and our foreign counterparts in order to ensure that they stay abreast of changes within this dynamic criminal environment. Our instructors have also provided their expertise in this area through published articles focusing on drug endangered children, booby traps, and personal protective equipment.

Hazardous Waste Cleanup

In FY 1988, the DEA's Hazardous Waste Disposal Program was established to assist our Special Agents in the management of the chemicals, waste and contaminated equipment seized at clandestine drug laboratories. Funding for this program was initially provided through the Asset Forfeiture Fund. In 1998, the DEA began receiving funding from the COPS program, and DEA Appropriated Funds in FY 1999, to support the cleanup of clandestine drug laboratories seized by state and local law enforcement. Together with the Asset Forfeiture Fund, these funding sources continue today.

When a federal, state or local agency seizes a clandestine methamphetamine laboratory, Environmental Protection Agency regulations require the agency to ensure that all hazardous waste materials are safely removed from the site. To facilitate the removal of these materials, in 1991, the DEA awarded the first private sector contracts for hazardous waste cleanup and disposal. This program promotes the safety of law enforcement personnel and the public by using qualified companies with specialized training and equipment to the remove hazardous waste seized at clandestine drug laboratories. These contractors now provide response services to DEA, as well as state and local law enforcement officials nationwide. These contracts serve communities by removing the source-chemicals that may pose threats to the public, which also helps to protect the environment.

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 over 10,000. The cost of administering these state and local cleanups in FY 2004 was approximately $17.8 million. Since we first began using contractor services in the early 1990s, the number of cleanups has skyrocketed, though the average cost per cleanup has greatly decreased. The average cost per

cleanup during the initial contract was approximately $17,000. During FY 2002, the average cleanup cost dropped to approximately $3,300, and currently, the average cost per cleanup is approximately $2,000.

To further reduce the cost of lab cleanups, in FY 2004, we joined the Kentucky State Police to establish a pilot, clandestine lab "container program", in Kentucky. The program allows trained Kentucky law enforcement officers to safely package and transport hazardous waste from the clandestine laboratory sites to a centralized secure container that meets all hazardous waste storage requirements. The waste is subsequently kept in the container until it can be removed by a DEA contractor. The container program has streamlined the laboratory cleanup process, by enabling law enforcement officials to manage small quantities of seized chemicals more quickly and efficiently. This container program has resulted in the reduction of operational costs, the length of time officers must remain at the lab sites, and the resulting overtime costs to law enforcement agencies. The current average cost of cleanup in this project is approximately $350 (Note: this average cost is through the end of the third quarter of FY 2005. This does not take into consideration the cost of state/local personnel, training, equipment and start-up, operational and maintenance costs associated with the temporary storage areas). We are currently working to expand this program to several other states.

Victim Witness Assistance Program and Drug Endangered Children

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

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

We also provide training on drug endangered children to federal, state and local law enforcement and to national, state and local victim organizations. The DEA serves as a resource for child protective service and school social workers, first responders, mail carriers and utility company personnel, all of whom may come in contact with labs and victims.

In order to provide the public with current information on methamphetamine and drug endangered children, the DEA participates in numerous local, state and national conferences and

exhibits. The issue of victim services is included as part of our Basic Agent Training, and also is presented to our management across the country.

The DEA recognizes that children exposed to methamphetamine are uniquely vulnerable to abuse and neglect. During the President's first term, the Administration began working with states to help implement Drug Endangered Children (DEC) programs, which establish teams of specialists to respond to situations where minors are found in or near methamphetamine laboratories, and are frequently sickened or burned from exposure to toxic chemicals. These programs are now operating in 25 states, with most being initiated with federal support. Additional teams are being developed across the country, and the Department of Justice and the Office of National Drug Control Policy (ONDCP) will continue to work directly with states to expand the DEC program.

Conclusion

Methamphetamine continues to take a terrible toll on this nation. The DEA is attacking this epidemic on all available fronts. The DEA's enforcement efforts are focused not only on the large-scale methamphetamine trafficking organizations distributing this drug in the U.S., but also on those involved in providing the precursor chemicals necessary to manufacture this poison.

The DEA is also working closely with our state and local law partners to assist in the elimination of the small toxic labs that have spread across the country like a wildfire. The DEA provides vital training and protective equipment to better prepare state and local law enforcement officers to investigate and dismantle these labs. The DEA's Hazardous Waste Program, with the assistance of grants to state and local law enforcement, supports and funds the cleanup of a majority of the laboratories seized in the United States. Over the years, this process has become more efficient and the cost per cleanup has been greatly reduced. The DEA has also taken an active role in the Victim Witness Assistance Program to assist methamphetamine's victims.

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, Ms. Birkmeyer.

STATEMENT OF LAURA J. BIRKMEYER

Ms. BIRKMEYER. Chairman Souder and distinguished members of the subcommittee. It is a true honor to appear before you today to discuss the plight of America's drug-endangered children. I am the Executive Assistant U.S. Attorney in the southern district of California, and I have prosecuted methamphetamine and precursor chemical cases for most of my 18 years there.

But today, I address you as director of the National Alliance for Drug Endangered Children. The alliance encourages communities to intervene on behalf of children and to establish Drug Endangered Children [DEC], multidisciplinary programs to rescue, defend and shelter and support these children.

Methamphetamine is running ferociously throughout the country, and in its wake, often unseen and overlooked are thousands of children. Drug endangered children are at enormous risk in homes where meth is manufactured or where parents live a methamphetamine life-style.

If this were a different venue I would present to you the hundreds of pictures and video clips we have collected of deplorable living conditions evidencing the homes of these children. Words don't adequately describe the filth, chaos and danger there. Their homes—where their sheets, if there are any, are never washed, where children's bedrooms are used to store drugs, where toxic waste from methamphetamine manufacturing is routinely poured down kitchen sinks and bathtubs in which children are later bathed. There are homes where the plumbing doesn't work, food in the refrigerator is moldy and rotten, and where if there is any food, many times it is contaminated because often times methamphetamine and methamphetamine chemicals are stored there.

There are also the homes where doorbells ring all day and night during binge cycles and where a constant stream of strangers, ex-felons, registered sex offenders and poly drug users come and go to use meth. The air is filled with second hand methamphetamine smoke that is precipitating out on surfaces throughout the house. The children are "parentified," they are left to look out for themselves and their younger siblings while their parents binge, sleep and cope with their drug habit.

I could also spread before you murdered, burned, bruised and maimed children who are victimized by these same adults. This is just the tip of the iceberg. All of these children, even those that emerge without serious bodily injury, suffer enormous psychological harm, degradation and lack of nurturing. Methamphetamine affects the body, and particularly the brain in a way that lingers long after ingestion occurs.

NIDA Director Nora Volkow and others have just begun to show that methamphetamine alters brain chemistry for months and years after the drug use ceases. The affects on the brain alter parental behavior and impair the ability to parent. Often parents in drug treatment do not recover in sufficient time and prove competent enough to be reunified with their children.

Just yesterday, the alliance brought together a working group of drug treatment experts to identify the most effective methamphet-

amine programs and to evaluate and recommend programs which address the total needs of family and their dependent children.

We are also in the process of designing an awareness program used to notify drug treatment providers who are sometimes unaware of the dangerous consequences for dependent children when their parents relapse. I know you are familiar with the El Paso Intelligence Center statistics.

You also probably know that we cannot count the total number of drug-endangered children in this Nation. We know that the El Paso numbers are not complete. Some counties are starting to count their drug endangered children on their own and in my home county, DEC teams have taken more than 400 children into protective custody in the past 12 months. Significantly more than 95 percent of those come not from meth lab homes but from homes where adults use methamphetamine or traffic in methamphetamine.

Drug endangered children teams comprised of law enforcement, child welfare workers, medical professionals, psychologists, prosecutors, and where possible, working closely with drug courts and court-appointed special advocates, are an effective response.

Drug endangered children, once they are found by law enforcement and protected by child custody are evaluated for placement in safer environments as non-offending parents, family members or in the foster care system. And a prosecutor will later determine if it's appropriate to file child endangerment charges or to permit reunification with parents.

As those children enter foster care they stress a system that searches for a way to coordinate a provision of services. Many communities are reporting that we need better preparation of foster parents for the behavior and medical issues attendant to children exposed to methamphetamine environments. State and counties have different resources and structures, and there is no one-size-fits-all for implementing a model of DEC. In order to implement that process, last year we started the National Drug Endangered Children training program administered by my office, which provides cost-free break to requesting States.

We send out experienced training teams consisting of law enforcement officers, prosecutors, doctors and nurses, the people that actually do this day in and out. In the last 18 months, we have trained more than 5,500 professionals for multiple disciplines in 20 different States. I wish to finish with a note of hope. The psychologists who work with the alliance say that these children are resilient. If given the opportunity and a caring environment they will strive. We have, as one of our goals, the hope that they will not be tagged "crank babies" as if they are irreversibly damaged. We believe, and it is our fervent shared belief, that by rescuing these children, we can break the cycle of drug abuse.

Thank you. I would be happy to answer any questions you may have.

[The prepared statement of Ms. Birkmeyer follows:]

Department of Justice

STATEMENT

OF

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

BEFORE THE

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

CONCERNING

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

PRESENTED ON

JULY 26, 2005

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

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

The Plight of Drug Endangered Children

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implementing DEC Programs in our Nation

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

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

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

An Evolving Response to the Problem

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

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

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

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

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

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

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

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

The Future

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

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

Mr. SOUDER. Thank you, I would recognize Mr. Cummings.

Mr. CUMMINGS. Thank you, Mr. Chairman, and I thank the witnesses for their testimony. Mr. Chairman I will give my statement at this time. Methamphetamine or meth is hardly a new drug, but in recent years, it has quickly become one of the major drug threats facing this country. According to a recent report by the National Association of Counties, entitled the Meth Epidemic in America, meth is now the No. 1 illegal drug threat facing most of the 500 counties that participated in a survey of local law enforcement agencies. Moreover, the drug's destructive impact on families has contributed to a significant increase in child welfare rolls as we have just heard in hundreds of counties across the Nation, according to the same record. The New York Times described meth's devastating impact on families in a compelling article published on July 8, 2005, entitled, "Drug Scourge Creates its Own Form of Orphan."

I would ask unanimous consent, Mr. Chairman, that article be submitted as a part of this hearing's record.

[The information referred to follows:]

The New York Times
nytimes.com

July 11, 2005

A Drug Scourge Creates Its Own Form of Orphan

By KATE ZERNIKE

TULSA, Okla., July 8 - The Laura Dester Shelter here is licensed for 38 children, but at times in the past months it has housed 90, forcing siblings to double up in cots. It is supposed to be a 24-hour stopping point between troubled homes and foster care, but with foster homes backed up, children are staying weeks and sometimes months, making it more orphanage than shelter, a cacophony of need.

In a rocking chair, a volunteer uses one arm to feed a 5-day-old boy taken from his mother at birth, the other to placate a toddler who is wandering from adult to adult begging, "Bottle?" A 3-year-old who arrived at dawn shrieks as salve is rubbed on her to kill the lice.

This is a problem methamphetamine has made, a scene increasingly familiar across the country as the number of foster children rises rapidly in states hit hard by the drug, the overwhelming number of them, officials say, taken from parents who were using or making methamphetamine.

Oklahoma last year became the first state to ban over-the-counter sales of cold medicines that contain the crucial ingredient needed to make methamphetamine. Even so, the number of foster children in the state is up 16 percent from a year ago. In Kentucky, the numbers are up 12 percent, or 753 children, with only seven new homes.

In Oregon, 5,515 children entered the system in 2004, up from 4,946 the year before, and officials there say the caseload would be half what it is now if the methamphetamine problem suddenly went away. In Tennessee, state officials recently began tracking the number of children brought in because of methamphetamine, and it rose to 700 in 2004 from 400 in 2003.

While foster populations in cities rose because of so-called crack babies in the 1990's, methamphetamine is mostly a rural phenomenon, and it has created virtual orphans in areas without social service networks to support them. in Muskogee, an hour's drive south of here, a group is raising money to convert an old church into a shelter because there are none.

Officials say methamphetamine's particularly potent and destructive nature and the way it is often made in the home conspire against child welfare unlike any other drug.

It has become harder to attract and keep foster parents because the children of methamphetamine arrive with so many behavioral problems; they may not get into their beds at night because they are so used to sleeping on the floor, and they may resist toilet training because they are used to wearing dirty diapers.

"We used to think, you give these kids a good home and lots of love and they'll be O.K.," said Esther Rider-Salem, the manager of Child Protective Services programs for the State of Oklahoma. "This goes above and beyond anything we've seen."

Although the methamphetamine problem has existed for years, state officials here and elsewhere say the number of foster children created by it has spiked in the last year or two as growing awareness of the drug problem has prompted more lab raids, and more citizens reporting suspected methamphetamine use.

Nationwide, the Drug Enforcement Administration says that over the last five years 15,000 children were found at laboratories where methamphetamine was made. But that number vastly understates the problem, federal officials say, because it does not include children whose parents use methamphetamine but do not make it and because it relies on state reporting, which can be spotty.

On July 5, the National Association of Counties reported that 40 percent of child welfare officials surveyed nationwide said that methamphetamine had caused a rise in the number of children removed from homes.

The percentage was far higher on the West Coast and in rural areas, where the drug has hit the hardest. Seventy-one percent of counties in California, 70 percent in Colorado and 69 percent in Minnesota reported an increase in the number of children removed from homes because of methamphetamine.

In North Dakota, 54 percent of counties reported a methamphetamine-related increase. At what was billed as a "community meeting on meth" in Fargo this year, the state attorney general, Wayne Stenehjem, exhorted the hundreds of people packed into an auditorium: "People always ask, what can they do about meth? The most important thing you can do is become a foster parent, because we're just seeing so many kids being taken from these homes."

Officials also say methamphetamine has made it harder to reunite families once the child is taken; 59 percent of those surveyed in the national counties study agreed.

The federal Adoption and Safe Families Act of 1997, enacted as babies born to crack users were crowding foster care, requires states to begin terminating parental rights if a child has spent 15 out of 22 months in foster care. It was intended to keep children from languishing in foster homes. But rehabilitation for methamphetamine often takes longer than other drugs, and parents fall behind the clock.

"Termination of parental rights almost becomes the regular piece," said Jerry Foxhoven, the administrator of the Child Advocacy Board in Iowa. "We know pretty early that these families are not going to get back together."

The drug - smoked, ingested or injected - is synthetic, cheap and easy to make in home labs using pseudoephedrine, the ingredient in many cold medicines, and common fertilizers, solvents or battery acid. The materials are dangerous, and highly explosive.

"Meth adds this element of parents who think they are rocket scientists and want to cook these chemicals in the kitchen," said Yvonne Glick, a lawyer at the Department of Human Services in Oklahoma who works with the state's alliance for drug endangered children. "They're on the couch watching their stuff cook, and the kids are on the floor watching them."

The drug also produces a tremendous and long-lasting rush, with intense sexual desire. As a result of the sexual binges, some child welfare officials say, methamphetamine users are having more children. More young children are entering the foster system, often as newborns suffering from the effects of

their mother's use of the drug.

Oklahoma was recently chosen to participate in a federally financed study of the effects of methamphetamine on babies born to addicted mothers. Doctors who work with them have already found that the babies are born with trouble suckling or bonding with their parents, who often abuse the children out of frustration.

But the biggest problem, doctors who work with children say, is not with those born under the effects of the drug but with the children who grow up surrounded by methamphetamine and its attendant problems. Because users are so highly sexualized, the children are often exposed to pornography or sexual abuse, or watch their mothers prostitute themselves, the welfare workers say.

The drug binges tend to last for days or weeks, and the crash is tremendous, leaving children unwashed and unfed for days as parents fall into a deep sleep.

"The oldest kid becomes the parent, and the oldest kid may be 4 or 5 years old," said Dr. Mike Stratton, a pediatrician in Muskogee, Okla., who is involved with a state program for children exposed to drugs that is run in conjunction with the Justice Department. "The parents are basically worthless, when they're not stoned they're sleeping it off, when they're not sleeping they don't eat, and it's not in their regimen to feed the kids."

Ms. Glick recalls a group of siblings found eating plaster at a home filled with methamphetamine. The oldest, age 6, was given a hamburger when they arrived at the Laura Dester Shelter; he broke it apart and handed out bits to his siblings before taking a bite himself.

Jay Wurscher, director of alcohol and drug services for the children and families division of the Oregon Department of Human Services, said, "In every way, shape and form, this is the worst drug ever for child welfare."

Child welfare workers say they used to remove children as a last resort, first trying to help with services in the home.

But everywhere there are reminders of the dangers of leaving children in homes with methamphetamine. In one recent case here, an 18-month-old child fell onto a heating unit on the floor and died while the parents slept; a 3-year-old sibling had tried to rouse them.

The police who raid methamphetamine labs say they try to leave the children with relatives, particularly in rural areas, where there are few other options.

But it has become increasingly clear, they say, that often the relatives, too, are cooking or using methamphetamine. And because the problem has hit areas where there are so few shelters, children are often placed far from their parents. Caseworkers have to drive children long distances to where parents are living or imprisoned for visits; Leslie Beyer, a caseworker at Laura Dester, logged 3,600 miles on her car one month.

The drain of the cases is forcing foster families to leave the system, or caseworkers to quit. In some counties in Oklahoma, Ms. Rider-Salem said, half the caseworkers now leave within two years.

After the ban on over-the-counter pseudoephedrine was enacted - a law other states are trying to

emulate - the number of children taken out of methamphetamine labs and into the foster care system in Oklahoma declined by about 15 percent, Ms. Glick said. But she said the number of children found not in the labs but with parents who were using the drug had more than compensated for any decline.

The state's only other children's shelter, in Oklahoma City, was so crowded recently that the fire marshal threatened to shut it down, forcing the state to send children to foster families in far-flung counties.

At Laura Dester, three new children arrived on one recent morning, the 3-year-old being treated for lice and two siblings, found playing in an abandoned house while their mother was passed out at home. The girl now wanders with a plastic bag over her hair to keep the lice salve from leaking. She hugs her little brother, then grabs a plastic toy phone out of his hand, leaving him wailing.

"Who's on the phone?" asks Kay Saunders, the assistant director at the shelter, gently trying to intervene.

"My mom," the girl says, then turns to her little brother. "It's ringing!"

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Mr. CUMMINGS. A powerful stimulant that affects the central nervous system, meth is derived from a chemical compound contained in over-the-counter nasal decongestants and bronchial inhalers as well as in certain weight loss treatments. Meth can be smoked, snorted, orally ingested or injected and is known by a variety of street names depending on the form in which it is used. Meth frequently is produced in a powder form, resembling granulated crystals and also in a rock form known as ice, which is referred by those who smoke the drug.

Meth causes an increase rush and a high that can last up to 12 hours. The side effects of meth use are dangerous and sometimes fatal. They include convulsions, high body temperatures, stroke, cardiac arrests, arrhythmia, stomach cramps and shaking. Meth is highly addictive and abuse of a drug can cause violent behavior, anxiety, insomnia in addition to psychotic affects such as paranoia, hallucinations, mood swings and delusions.

Persistent users develop a tolerance for the drug that requires the user to take increasing amounts to achieve the desired affects. Meth can be manufactured using ingredients purchased in U.S. retail stores. Most of the production of U.S.-consumed methamphetamine is domestic, occurring both in large super labs, which produce unprecedented amounts of high purity methamphetamine, as well as in small, clandestine labs found in homes, apartments, hotel rooms, rented storage space and trucks. Many methamphetamine labs produce as little as 10 pounds a year, but their environmental costs in the cleaning up of toxic wastes from these sites can be huge. Because the ingredients are not only toxic but extremely volatile in combination labs also pose a serious danger to the so-called meth cooks who make the drugs, as well as individuals living in close proximity to the activity.

All too often, these individuals are the young children of small-scale manufacturers. They are not only at great risk of physical harm, from explosions, exposure to toxic chemicals, but they are very often the victims of family neglect or abuse, because the drug's affects on their parents or other relatives.

A National Association of Counties report, and "New York Times" article described, these circumstances have led to a large number of children being taken from the custodial control of their parents and placed in foster care. Sadly the health and behavior affects that result from prenatal exposure to meth and from severe family neglect or abuse make meth-addicted parents especially challenging for foster parents to care for and very, very difficult to place. Absent effective treatment for the parents of displaced children, reuniting families, torn apart by meth, may be impossible.

Traditionally, meth has been concentrated in the western States, especially California, Arizona and Utah. In recent years, the midwest region has experienced tremendous growth in both trafficking and production, and that activity is spreading into the southeast and northeast regions. Meth abuse has not yet become a major problem in the communities of Baltimore City and Baltimore-Howard counties that I represent, but the rapid spread of meth production, trafficking and abuse in the United States, underscores the fact that America's drug problem affects all parts of America and

that no community, absolutely no community, is immune to the introduction of a dangerous new drug threat.

Today, on our first witness panel, we will hear from officials who are responsible for shaping, coordinating and carrying out the Federal response to the growing meth epidemic, including preventing its spread to the East Coast and urban districts like the one that I represent.

We will also hear directly from law enforcement and child welfare officials from States and localities that are suffering the myriad of problems that affect communities where meth is produced and consumed.

Federal legislative efforts to address the meth epidemic have focused on limiting over-the-counter access to products containing precursor chemicals as well as providing support for law enforcement and the cleanup of toxic sites. There is no doubt that these are important objectives that Congress and the administration should pursue.

At the same time, Mr. Chairman, I believe that it would be impossible to underestimate the importance of drug treatment in addressing this epidemic. Research from the Center for Substance Abuse Treatment shows that meth addiction can be effectively treated and that the benefits of treating meth addiction are similar to the benefits derived from treating addiction to other drugs. Use of the drug is sharply reduced. Criminal activity and recidivism decline. Employment status and housing status improve, and overall health improves—a healthy drug-free employed person in a stable housing situation is a person who is far more likely to be able to function in civil society and be a responsible, loving parent—of insuring that people who have become dependent on meth have access to effective treatment is therefore essential to stopping this epidemic that is sweeping across our great Nation.

So, Mr. Chairman, I thank you for continuing to shine a light on this issue. I thank each of our witnesses for appearing with us today.

With that, Mr. Chairman, I yield back.

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

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

Hearing on "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies""

July 26, 2005

Mr. Chairman,

Methamphetamine, or "meth," is hardly a "new" drug but in recent years it has quickly become one of the major drug threats facing our nation.

According to a recent report by the National Association of Counties, "The Meth Epidemic in America," meth is now the number one illegal drug threat facing most of the 500 counties that participated in a survey of local law enforcement agencies. Moreover, the drug's destructive impact on families has contributed to a significant increase in child welfare rolls in hundreds of counties across the nation, according to the same report. *The New York Times* described meth's devastating impact on families in a compelling article published on July 8, 2005, entitled "Drug Scourge Creates Its Own Form

of Orphan" – and I would ask unanimous consent that the article be submitted in the hearing record.

A powerful stimulant that affects the central nervous sytem, meth is derived from a chemical compound contained in over-the-counter nasal decongestants and bronchial inhalers as well as in certain weight loss treatments. Meth can be smoked, snorted, orally ingested, or injected, and is known by a variety of street names, depending upon the form in which it is used. Meth frequently is produced in a powder form resembling granulated crystals and also in a rock form known as "ice," which is preferred by those who smoke the drug.

Meth causes an intense rush and a high that can last up to twelve hours. The side effects of meth use are dangerous and sometimes fatal; they include convulsions, high body temperature, stroke, cardiac arrhythmia, stomach cramps, and shaking. Meth is highly addictive and abuse of the drug can cause violent behavior, anxiety, and insomnia, in addition to psychotic effects such as paranoia, hallucinations, mood swings, and delusions. Persistent users develop a tolerance for the drug that requires the user to take increasing amounts to achieve the desired effects.

Because meth can be manufactured using ingredients purchased in U.S. retail stores, most of the production of U.S.-consumed methamphetamine is domestic – occurring both in large "superlabs," which produce unprecedented amounts of high-purity methamphetamine, as well as in small "clandestine" labs found in homes, apartments, hotel rooms, rented storage spaces, and trucks.

Many clandestine labs produce as little as ten pounds of meth a year, but their impact on the environment, and the cost of cleaning up the toxic waste from these sites, can be huge. Because the ingredients are not only toxic, but extremely volatile in combination, labs also pose a serious danger to the so-called "meth cooks" who make the drug as well as individuals living in close proximity to the activity.

All too often, these individuals are the young children of small-scale manufacturers and they are not only at great risk of physical harm from explosions or exposure to toxic chemicals, but they are very often victims of family neglect or abuse because of the drug's effects on their parents or other relatives.

As the National Association of Counties report and the New York Times article describe, these circumstances have led to a large number of children being taken from the custodial control of their parents and placed in foster homes. Sadly the health and behavioral effects that result from prenatal exposure to meth and from severe family neglect or abuse make the children of meth-addicted parents especially challenging for foster families to care for and difficult to place. Absent effective treatment for the parents of displaced children, reuniting families torn apart by meth may be impossible.

Traditionally, meth has been concentrated in the Western states, especially California, Arizona, and Utah. In recent years, the Midwest region has experienced tremendous growth in both trafficking and production, and that activity is spreading into the Southeast and Northeast regions.

Meth-abuse has not yet become a major problem in the communities of Baltimore City and Baltimore and Howard Counties that I represent. But the rapid spread of meth production, trafficking, and abuse in the United States underscores the fact that America's drug problem affects all parts of America and that no

community is immune to the introduction of a dangerous new drug threat.

Today, on our first witness panel, we will hear from officials who are responsible for shaping, coordinating and carrying out the federal response to the growing meth epidemic, including preventing its spread to the east coast and urban districts like my own. We will also hear directly from law enforcement and child welfare officials from states and localities that are suffering the myriad problems that affect communities where meth is produced and consumed.

Federal legislative efforts to address the meth epidemic have focused on limiting over the counter access to products containing precursor chemicals as well as on providing support for law enforcement and the clean up of toxic sites. There is no doubting that these are important objectives that Congress and the Administration should pursue.

At the same time, Mr. Chairman, I believe it would be impossible to underestimate the importance of drug treatment in addressing this epidemic. Research from the Center for Substance Abuse Treatment shows that meth addiction can be effectively treated

and that the benefits of treating meth addiction are similar to the benefits derived from treating addiction to other drugs: use of the drug is sharply reduced, criminal activity and recidivism decline, employment status and housing status improve, and overall health improves.

A healthy, drug-free, employed person in a stable housing situation is a person who is far more likely to be able to function in civil society and to be a responsible, loving parent. Ensuring that people who have become dependent upon meth have access to effective treatment is therefore essential to stopping this epidemic that is sweeping across our country.

Thank you, Mr. Chairman, for continuing to shine a light on this issue in this Subcommittee. I thank each of our witnesses for appearing before us today and I look forward to their testimony.

Mr. SOUDER. Before we move to questions, Mr. Mica, do you wish to make an opening statement.

Mr. MICA. Thank you, Mr. Chairman, thank you for recognizing me. I didn't get a chance to make an opening statement, but if you would permit me just to make a few comments.

First of all, I thank you for this hearing. I rarely try to write and direct the actions of this subcommittee, although I had the honor and privilege of being a former Chair of this panel. But as you know, I requested that we look at this issue. The meth issue is totally out of hand. I have worked on this subcommittee with you and other predecessors back at—before Denny Hastert.

We have tackled crack and cocaine issues. I have worked with Mr. Cummings in trying to clean up Baltimore and some of the challenges we faced in that community and other communities. We have been through heroin. We have tracked down perpetrators to the Andes, we have put together multibillion dollar programs to go after drugs at their sources, illegal narcotics at their sources. We have been through the designer drug phase.

Now we are at an interesting juncture where we have done some good things in some of those areas. But this problem is in everybody's backyard in this Congress and in every community across the country. It's almost totally out of hand. It's our worst drug nightmare come true, because the ingredients are easily accessible in drugstores. The recipes are on the Internet.

If you look at crime tragedy and social problems in this country right now, spousal abuse, child abuse—I remember one time hearing the story of—it is affecting every aspect of our society. All the social levels, whether it's a rich family that puts their baby—the mother puts the baby in a microwave and tries to fry her, or in some of the poorest backwaters of our country, this is a serious problem, out of hand. I honestly don't know what the answer is. I think if you get to treatment, it is probably too late. They have already destroyed lives and families, because, again, of the insidious nature of this drug.

We have to look at again, education. We may need to haul some folks in. I am anxious to hear what they recommend. We need to look at our laws. We need to look at enforcement, whatever it takes. But this situation is totally out of hand, and we have to come up with some solution to bring all the resources possible to address this.

So I thank you for calling this hearing. I am anxious to not only hear the testimony, but also hear some of the solutions that are suggested by some of the expert witnesses you have assembled. So thank you and I yield back.

Mr. SOUDER. Ms. Watson, do you have any opening comments?

Ms. WATSON. Thank you so much, Mr. Chairman, for putting together this hearing today. Because eliminating drug smuggling and distribution throughout the United States is vital in keeping our communities safe. The Department of Justice contends that in my home State of California, we have over 80 percent of the Nation's meth labs, and, therefore, we are the leading exporter of this deadly drug.

In 2002 to 2004, 142,749 people were treated for meth treatment in my State alone. I am very troubled by the fact that I believe that

over 12 million Americans, ages 12 and older, have tried methamphetamine at least once in their lives. These statistics are startling as well as devastating. And our youth, being the future of this Nation, and the fight to decrease the distribution of this drug, along with all other illegal substances, should be at the forefront of all of our efforts.

Throughout this hearing, we will discuss the impact on methamphetamines on the child welfare system. We are seeing a growing trend where every day more and more children are entering the foster care system because of meth, because of its manufacturing or because they are selling it. Our children are suffering from their parents' addiction to meth. Most of our youth who end up being users were introduced to meth by their parents or by other family members. The scope of the methamphetamine problem is not just the users and distributors problem, it is the problem of everyone who touches the life of someone who is using this harmful substance.

Methamphetamine use and distribution have disastrous consequences across America's heartland and beyond. So we must do everything in our power to expand access to treatment, strengthen our prevention services and continue to support research that will help us get rid of this problem here in the United States. We need to be focused on supplying treatment that will not only get the abuser off of drugs, but supply them with a job, help them remain out of jail and be a positive contributor to society.

So, Mr. Chairman, I thank you again for putting together this hearing, and I would like to thank the witnesses for their willingness to come and testify. I hope that we can all work together to effectively tackle the abuse of all illicit substances that are ruining our streets and killing our children every day.

Thank you.

[The prepared statement of Hon. Diane E. Watson follows:]

Opening Statement
Congresswoman Diane E. Watson
Government Reform Committee
Subcommittee on Criminal Justice, Drug Policy & Human Resources
Hearing: "Fighting Meth in America's Heartland: Assessing the Impact of Local Law Enforcement and Child Welfare Agencies"
July 26, 2005

Mr. Chairman, I thank you for holding this hearing that is critical to eliminating the constant influx of methamphetamines into our nation. Eliminating drug smuggling and distribution throughout the United States is vital in keeping our communities safe.

The Department of Justice contends that in my home state of California, we have over 80% of the nation's Meth labs and therefore are the leading exporter of this deadly drug. In 2002-2004, 142,749 people were admitted for meth treatment in my state alone. I am also very troubled by the fact that over 12 million Americans, ages 12 and older have tried methamphetamines at least once in their lives. These statistics are startling and devastating. Our youth are the future of this nation and a fight to decrease the distribution of this drug along with all other illegal substances should be at the forefront of our agenda.

Throughout this hearing we will discuss the impact on methamphetamines on the child welfare system. We are seeing a growing trend where everyday more and more children are entering the foster care system because of methamphetamine use, manufacturing, or selling. Our children are suffering from their parents' addiction to meth. Most of our youth who end up being users were introduced to meth by their parents or other family members. The scope of the methamphetamine problem is not just the users' and distributors' problem; it is the problem of everyone who touches the life of someone who is using this harmful substance.

Methamphetamine use and distribution have disastrous consequences across America's heartland and beyond. This body must do everything in its power to expand access to treatment, strengthen prevention services, and continue to support research that help us rid this problem in the United States. We need to be focused on supplying treatment that will not only get the abuser off of

drugs, but supply them with a job, help them remain out of jail, and be a positive contribution to society.

Thank you again Mr. Chairman for putting together this important hearing. Also, I would like to thank the witnesses for their willingness to come testify. I hope that we can all work together to effectively tackle the abuse of all illicit substances that are ruining our streets and killing our children everyday.

Mr. SOUDER. Thank you. Like Congressman Cooper, Congressman Osborne is not a member of this committee, but he has been a leader in the fight against meth. Would you like to make any comments.

Mr. OSBORNE. No statement.

Mr. SOUDER. Mr. Burns, before this hearing, you met with the bipartisan caucus leaders, Congressman Calvert, Congressman Larsen, Congressman Baird.

Mr. BURNS. Yes.

Mr. SOUDER. They had specifically asked you to come back with what the Federal Government was doing in a coordinated way to tackle the problem of meth. Could you elaborate on that a little bit and what your plans are to come back to the meth efforts we have been organizing aggressively here in Congress? And we would like to hear what the administration is doing.

Mr. BURNS. Yes, let me start by saying, as many of you know who have followed this issue, we had great successes in stemming the flow of pseudoephedrine from Canada into Central Valley, CA, Congresswoman Watson, your State. We saw a drastic reduction in the number of super labs, super labs being a lab that can produce 10 pounds or more methamphetamine in a 24-hour period.

We saw those labs, we believe, go south to Mexico. So the strategy this the administration had, Ms. Birkmeyer and Mr. Rannazzisi and our brothers and sisters in law enforcement and across the country, had a year ago has changed. This is not an issue that you can come up with the solution, that is, forever going to work. So I look forward, and I am pleased that the meth caucus has agreed to sit down with us and look at the immediate and best practices we can employ to making the problem smaller.

With respect to moving the meth to Mexico, for example—and I have talked about a synthetic action plan that we have come up with. There are efforts underway and the meth caucus has agreed to assist us in dealing with China, Hong Kong, Czech Republic and Germany and other countries that export pseudoephedrine, primarily and formerly to Canada, but now primarily to Mexico. Any assistance that can be provided in conjunction with the administration will be well received.

Ms. Birkmeyer and the national methamphetamine chemical initiative, now I am talking about the domestic side of methamphetamine, bringing together law enforcement officers from Florida and from Nebraska and from North Carolina and every State in this country, Indiana, to look at best practices and to make recommendations to us with respect to what will work—who better than the women and men in the field and in the trenches of these sheriffs and folks behind us that give us——

Mr. SOUDER. Mr. Burns, I appreciate that.

Mr. BURNS. Sure.

Mr. SOUDER. What we want to see are not the piecemeal efforts which have been extraordinary. We want to see a coordinated effort. This is not a new drug. It didn't just suddenly burst on the scene. We held the first hearings under Mr. Mica in Congressman Ose's district right before California passed their childhood endangerment law, and it had to be at least 8 years ago when this hit California. It has been steadily moving across the country.

What we see are individual HIDTAs having to come bottom up. We see individual programs being coordinated around the State. We see no national coordinating meth strategy. What I would like to see is not how is this piece and how we are going to do this and that.

In the past 3 weeks, we have passed more pieces of legislation on meth which the administration could have been doing, which the administration could have done, but didn't do. We are going to keep the pressure on. What the meth caucus wants to hear are not the pieces but the overall strategy. How does this strategy tackle this?

The Canada bust was tremendous. It dried up a portion of the pseudoephedrine across the border. There are only nine of these plants in the entire world. This isn't that hard. It is not going to be that easy, but we want to see a coordinated strategy.

Just a little over a week ago, the Attorney General said that meth was an epidemic, which is not what we have been hearing out of the government, and he said it is the most dangerous drug in America. Does ONDCP agree with that? Do you think that is the most dangerous drug in America?

Mr. BURNS. I don't think anyone would disagree with Attorney General Gonzales and his statement regarding the destructive nature of methamphetamine. I don't know that he called it an epidemic.

Mr. SOUDER. That is a quote.

Mr. BURNS. I made the same statement in Portland, OR, a couple of weeks ago. Based upon my experience there is no more serious drug in the country. But as you know, and as the Office of National Drug Control Policy, we also have to deal with heroin in the northeast where they would laugh if you told them there is a meth epidemic. We have to deal with gangs in Chicago who would laugh if we told them there is a meth epidemic. We have to deal with the fact that there are more kids in treatment for marijuana than all the other kids combined and 75½ million are using that drug. We have to be able to address all of the drugs and all of the problems on a comprehensive——

Mr. SOUDER. So you don't agree it is the most dangerous drug in America. In other words, its rate of increase, the way it grabs, it's impact on the State and local law enforcement. Look, I want to say for the record, you have been an ally on this internally——

Mr. BURNS. Thank you.

Mr. SOUDER [continuing]. And it has been very difficult. But we are not arguing that cocaine isn't a dangerous drug or that heroin isn't a dangerous drug, but they are relatively flat. What we are seeing, as many of the African-American interim big city organizations realize they can cut out the Colombians, go straight with the Mexicans, and when they convert over to meth, we are going to see an epidemic like never before in America as it hits the areas where they don't have an epidemic.

That is why the Attorney General says it is the most dangerous drug and we want the ONDCP to acknowledge it. One of those is my next question. The President with the active backing of ONDCP proposed cutting the HIDTA, the High Intensity Drug Trafficking Areas Program by 60 percent, which we have restored, in fact in-

creased, eliminating the Safe and Drug-free Schools State grants, which we put the money back for in Congress, eliminating the Burn grants to State and local law enforcement, which we will hear on our critical second panel, wiping out the Meth Hot Spots Program, which we have restored.

Now the question is, are ONDCP and the administration ready to say we were wrong—and as we go to conference here, are they going to back us on the meth questions—and if you are not prepared to say that today, I hope you will take it back to the Director of ONDCP and the White House that Congress has spoken. We need you not to come up and say, look, we are working on the meth piecemeal. We need you to stop cutting the budget on how we are trying to address it. We need you to back up the U.S. Congress as we try to move it forward and back up the State and local law enforcement, the DEA agents, in the field so they can stop this before we bemoan 2 years later that the statistics ate us alive.

Mr. BURNS. I will deliver the message, Congressman, I hear you loud and clear, I think we heard it loud and clear in the House and the Senate with respect to HIDTA and other assistance in State and local law enforcement.

As you mentioned prior to the hearing, I met with the meth caucus, met with Congressmen Larsen and Baird and Calvert and admitted that we would make an attempt to do it in a package fashion and not piecemeal and comprehensive. You and I see each other enough. You can make sure I do that.

Mr. SOUDER. Mr. Rannazzisi, is it the DEA position that India, Mexico, Germany, China, are cooperating with us at this point on the precursors? We put it in the State Department bill last week for data collection. What other tools do you have that we could help with?

Mr. RANNAZZISI. Well, I believe we are getting good cooperation from our international counterparts. Mexico—we are in constant contact with Mexico and Mexico recognizes the problem, recognizes that pseudoephedrine, as many could go into their country and we are working very closely with them, with their competent authority that handles the chemicals. They are looking at the problem just as strongly as we are.

As far as the other countries you mentioned, all of those countries have been more than cooperative with us, you know, on specific information. If we ask them, you know, they will provide the information. We all sit on the same international committees. It is not a one-on-one—it is more of a—like U.N. committees, for instance. We sit on U.N. committees, Operation Topaz, committees like that, where we actually share information on chemical flows through the world. So the cooperation is good.

Now, on the second part of your question, I am sorry, could you repeat that, please?

Mr. SOUDER. We would like specific suggestions you might have to enable us to make DEA more effective as you try to intercept the pseudoephedrine coming in. It is coming from a few known places, we have the data on that, known cooperation, there are obviously certification processes that the drug czar can recommend, administration can recommend and decertify countries if they don't cooperate. What kind of cooperation do we need in that area?

Mr. Placido, when he testified here a number of weeks ago, he promised he was going to provide a list to this committee a list of how DEA and the organized way it has been tackling meth, not—kind of generally gave us a couple of good programs he was working. My understanding is, is that still going through clearances? We need to see those documents.

We want to know what systemic way DEA is tackling this issue as a critical part of components. If I can add one last thing, you had the Kentucky program that was really interesting. That one of the things we have learned in the process here is our asset forfeiture laws may be weaker than they need to be as far as seizing certain assets in the home cooker cases. If you have any suggestions or informal advice you want to give to us as we develop those kinds of pieces of legislation and move forth in ways we might be able to put that in some of the cleanup costs, what we could do to go forward and help promote that program like you have in Kentucky, because that would be a big break through for local law enforcement.

Mr. RANNAZZISI. As far as what we are doing and what we need to do to go further, as far as the chemicals, that is something I am really not prepared to talk about. But I will get back to you, and I will get Mr. Placido and make sure those documents are completed and vetted and sent to the committee.

Mr. SOUDER. Thank you. Mr. Cummings.

Mr. CUMMINGS. Thank you very much. I want to thank all of you very much for your testimony. I want to go to you, Mr. Burns, and I just want to correct you on one thing. You had said in response to the chairman, one of the chairman's question, you said that if you, and you can correct me if I am wrong, I am not sure if I am paraphrasing that completely accurately, you said if you were to go to the northeast and said that there was a meth epidemic, that they would laugh at you, something of that nature?

Mr. BURNS. Yes.

Mr. CUMMINGS. Well, I am here to tell you that I am in the northeast, and we don't laugh at that, because we realize that for any person in this country, to suffer from drug addiction is like the entire country is suffering, whatever the drug may be. In my area it's heroin, and it is crack cocaine. But I believe that the people who go through that and see their families destroyed, see their communities destroyed, see their children's hopes and dreams not delayed, but snuffed out, they sympathize with anybody, anywhere, who is going through a similar problem, no matter what the drug of choice might be.

I just want to make that clear, because I think it's very important that all of us understand that no matter what the drug is, the destructive nature of drugs is universal, and it has no boundaries.

But let me just go to something else. In my opening statement, I talked about the effects of this meth, and I talked about violent behavior, I talked about psychotic effects. He talked about hallucinations and delusions. One of the things I think that concerns me greatly about methamphetamine, is that they can do the same thing that we have seen done in the inner city of Baltimore. They can create narco-terrorist's right in your own neighborhood.

They don't have to come from overseas somewhere. People are afraid to even go into their houses or come out of them. People are afraid that their own children will kill them. That is a very, very serious business. And so when Mr. Souder talks about solutions to the problems, I am just wondering exactly, why is it—and perhaps you might be able to help me with this, Ms. Birkmeyer.

Why is it that you think that 47 percent of the methamphetamine abusers are women? Why do you think that is?

Ms. BIRKMEYER. I am not an abuse expert.

Mr. CUMMINGS. OK. Maybe one of the gentlemen can tell me.

Ms. BIRKMEYER. I have learned through my travels, though, that because methamphetamine is a weight loss drug and women sometimes have the desire to appear to be slender, that it is appealing to them. It is a drug that gives you quite a bit of energy. And so in places that are rather—that you wouldn't think as being areas ripe for drug use, mothers who are raising a lot of children use it to stay awake.

Many young women are fed methamphetamine by boyfriends or by peers and become addicted to it. So it is a drug that crosses every sphere, as you all have noted, and it is very dangerous to women. And it has particular impact, because it is drug that is popular to women, it has particular impact on children.

Mr. CUMMINGS. Speaking of children, what would you like to see the Federal Government do with regard to the issues that you raise as far as parents not being there for their children? Because it appears that we may very well be creating a new negative generational cycle, that is, a generational cycle of drug addicts.

We have seen it, by the way, in my district where the mother, the child, the grandmother, grandfather, generation after generation of addicts.

You know, how do we try? I mean, what can the Federal Government do to deal with their problem? Because it does not seem that there is any letting up of folks who are becoming addicted. And at the same time, while we are trying, Mr. Burns and many others are trying to address the problem, we still have little children who are simply trying to grow up, not pulling themselves up by their bootstraps because they don't have any boots and no straps. They are just trying to make it.

And so how do we make sure that we—what can the Federal Government do to help folks in positions like yours, locals and States, deal with these kinds of issues? I am talking about the children aspect of it.

Ms. BIRKMEYER. I am hoping that beyond today's hearing you will permit the National Alliance to work with you, and I would love to be able to submit to you some plans and suggestions.

I mentioned earlier the fact that we believe very strongly in drug-endangered children [DEC] teams. And I can't submit to you how important that is. I would suggest that the reason we have seen these generational problems is because, in the past, we left the kids behind. After law enforcement did their hard work, cleaned up a house, arrested folks, seized drugs, the child was handed off to the first non-felon that walked through the door, was never identified as a crime victim and was often reunited with par-

ents as soon as they got out on bail. And nobody was recording that child as somebody that we needed to pay attention to.

The DEC team philosophy is completely different. It elevates the role of that child as a victim. It ensures that child welfare workers work in partnership with law enforcement. And one of the things that we urge at the National Alliance is, it is not just about the rescue.

Good for us that we rescue, good for us that we identify that child, but we need to follow that child long term. We have to make sure that immediately they get a medical exam appropriate for the type of environment they are found in. We know that we have to do developmental exams on them to see what this environment has done to them. We know we can't return them to parents until the parents are competent to be parents. And so that is a long-term goal.

I think we have done a fairly good job. Nobody was talking about drug-endangered children 5 years ago. I mean, I am sure all of you were in one sense or another, but we weren't identifying it as a national crisis or problem. I think we have made strides in terms of awareness. We have a long way to go. There is a lot that needs to be studied.

There is some ground-breaking research that has occurred, DEA chemists assisting the National Jewish Hospital and Medical Center in Denver, CO, and Dr. John Martyny have gone a long way to start the research we need to do about what are the true effects of the meth environment? How is it really contaminated? We have yet to really study what happens to a child in that environment.

You can't use a child as a guinea pig, of course, so we need to look at the children we are taking out of there and see, long term, how do they suffer? What are the developmental delays that we see?

We know that our treatment programs and even the great programs like drug court have to acknowledge the fact that there are children in the background when you are treating the adult, that if the adult has a relapse, you can't then send the adult home who may ignore or, worse yet, harm the child.

So I think we are doing a decent job on consciousness raising.

I would appreciate the opportunity to work with you and this committee in the future to submit suggestions. We have got a long list.

Mr. CUMMINGS. Thank you very much.

Mr. SOUDER. Yield to the vice chairman, Mr. McHenry.

Mr. MCHENRY. Thank you, Mr. Chairman. I will make this very brief, and it is a simple question.

What is your one suggestion for Congress in order to—what is the one thing we in Congress can do to attack this meth problem? And we can just start from left to right. I would like to hear your one suggestion, if you could just boil it down, keep it short and simple. I only have 5 minutes. I am not the chairman, I am not the ranking member.

Mr. BURNS. Well, I think Chairman Souder hit the nail on the head. I mean, sometimes it is difficult for us in the administration to keep up with Congress and the legislation that is being proposed and find out who is going where and when and why.

I think, if I had one suggestion to make, it would be that we make a concerted effort to sit down and come up with a comprehensive package to address the issue. That would be my one recommendation.

Mr. RANNAZZISI. I think that the recommendations that were put forth in the National Center Drug Action Plan should be taken seriously. And, basically, they are a very good starting point as far as where we should be down the road to combat methamphetamine.

Ms. BIRKMEYER. Mr. Burns stole the words right out of my mouth, and that is, a comprehensive approach. It is something that the National Methamphetamine Chemicals Initiative has been pushing since 1999. But particularly with respect to children, I think every time you look at this aspect of methamphetamine—and, mind you, drug-endangered children aren't exclusive to meth; you well know that a cocaine home or a marijuana home or a heroin home can be just as dangerous and terrifying to a child. But it really is all about comprehensive approach and thinking every time we do something, how is this going to affect children and how can we make sure that we get them the services they need.

Mr. MCHENRY. Thank you.

Mr. SOUDER. Ms. Foxx.

Ms. FOXX. Thank you, Mr. Chairman.

Mr. Burns suggested that the meth problem is not as bad or as broad as cocaine, heroin, and others. In our experience in North Carolina, meth certainly is a much bigger problem than other illicit drugs. If what you say is correct, however, it may not be correct for long.

What I mean by that is, widespread meth abuse is relatively recent, and meth may replace heroin, cocaine, and others as the worst drug problem in America. Hindsight shows us something we could have done differently when cocaine and heroin problems were developing. Learning from those lessons, what can we do to adapt them to fight meth ahead of the curve?

Mr. BURNS. Well, and perhaps I haven't articulated well, I was talking about looking at the problem from a national level.

And if I can go back, Ranking Member Cummings, and just respond briefly to your comment, I would never insinuate or state that there is anything humorous about any of this. I was talking about, on a national level, trying to look at cocaine and methamphetamine and marijuana.

I buried a brother 52 years old on July 8th who suffered the disease of addiction for 27 years. He was in a mining accident and never got off pills and never got off alcohol. My mother understands it, my remaining brother understands it, and I understand it. And there is nothing funny about it.

With respect to your question. All problems are personal. When I came to Washington, DC, from Cedar City, UT, the No. 1 issue that I brought, an area of expertise, was methamphetamine. Perception is reality. You are correct, however, that in different parts of the country, different law enforcement agencies and policymakers have to deal with their present problems.

What are we doing to send the message from the West Coast to the East Coast about best practices? Ms. Birkmeyer and Mr.

Rannazzisi have been with me on numerous town halls and summits and meetings to try to bring together Federal, State, and local law enforcement, to bring together members of communities.

We talk about educating people in the business community. We talk about the drug-endangered children program and training we can put together. We talk about educating law enforcement. We actually bring people from the West Coast to the East Coast.

I have been to Maine and New Hampshire and Connecticut and, most recently, Rhode Island. We are working on a summit there to talk about methamphetamine before they even have, frankly, a lab problem or meth problems, to try and get ahead of the problems. So that is what we are doing in the administration.

Ms. FOXX. Thank you.

Mr. SOUDER. Mr. Mica.

Mr. MICA. OK. Mr. Burns, this is a great report—I sent it to you, Mr. Chairman—from the Washington Times done by a Guy Taylor. They did a series. This one, this part of it, is entitled Meth's Infection: Labs Spread Bitterness to Communities, a series—part of a series.

In this he says, "In Tennessee, the Department of Child Services investigated meth-related cases involving more than 750 children from just last October to February alone."

Let us take another State quoted in here.

"Indiana reported a thousand raids"—that is your home State, Mr. Chairman—"on mom-and-pop meth labs. One of the sheriffs of Vigo County said the annual cost of running the jail jumped from $800,000 7 years ago to $3½ million last year. And he said 80 percent of its more than 250 prisoners are held on meth-related charges." Furthermore, this report says, "more than half of the local law enforcement representatives in 45 States surveyed this month by the National Association of Counties, NACo, listed meth before marijuana and cocaine."

That is an epidemic, OK? The Attorney General said it is an epidemic, the county and local officials are saying it is an epidemic. This is the most out of control I have ever seen, since I have served in Congress, of any narcotic. And we had them in the mid-1990's, dropping like flies in central Florida from the heroin epidemic, when we had people dying in those numbers.

My question is, on the education side, what kind of a targeted program and how much of our resources in dollars or percent of dollars are we spending to address this? Could you tell me?

Mr. BURNS. I couldn't give you a figure with respect to——

Mr. MICA. Well, that scares me if you can't give me a figure.

Mr. BURNS. Well, then be scared, because I can't. I mean, I can get back to you and try and figure out how much goes toward——

Mr. MICA. See, now that scares me, too, because when you have these kinds of statistics and we don't have a plan and we don't know how much money we are spending on it, there is something wrong.

This is an epidemic. This meeting to sit down should have occurred a long time ago. This isn't something just new on the block.

Mr. Souder and I were—he told you about 7, 8 years ago; and this has continued to build, and now it has reached a crescendo. It is affecting everybody. And we need a plan with—you know, we

helped get the education programs started in this subcommittee. We want those dollars spent where there is a problem, so some of that money needs to be diverted, a program needs to be developed.

Hell, if we operated our campaigns this way, well, let us just sit around and think about it, maybe we can target this group after the election, none of us would be here. And one of the reasons we put together a National Media Campaign was because we could focus attention, a message, and get it to where the problem or the issue was, the people that we want it to affect.

Quite frankly, I am disturbed because I don't see that happening.

From a law enforcement standpoint, we have one—let us see. We have the deputy officer of drug enforcement and Laura Birkmeyer, Joseph and Laura. What is the law enforcement—do we need to change Federal law? Do we need—what do we need to do? Do you have specific recommendations? Is there something missing that we can't do? I know the administration came up with changing some of the emphasis from the HIDTAs, and I supported that. It didn't meet very well here in targeting money, because the HIDTAs were supposed to go after high-intensity drug traffic.

Is that part of the problem, not the resources to get there? Money? Or is it laws? What is it from the law enforcement standpoint? One at a time.

Mr. BURNS. Well, sir, as far as the resources, again, currently, that is something that I couldn't answer at this hearing. It is something I would have to go back——

Mr. MICA. Well, OK.

You know what I would suggest, Mr. Chairman? We get the Attorney General and some of his folks, we get DEA and their folks, we get the U.S. attorneys, and anyone else who is involved in this, and we bring them together on an immediate basis. We need a plan.

You know, the kids have this "Sounds like a plan?" I don't hear anything that sounds like a plan. So we need a plan to deal with this from the law enforcement standpoint.

I love treatment. You know, treatment is great. But I will tell you, by the time you are treating these people, it is way too late in the game. They have already destroyed their lives, their families' lives, their kids' lives, and everybody else's lives in the process.

The other thing, too, we haven't done, Mr. Chairman. We need to go back and look at the way we are collecting statistics. Statistics today versus the way we have required these being put together don't show us the whole picture. I don't know if the subcommittee needs to work on legislation.

We are looking at the whole picture. You know, we look at 26,000—now we are up to—drug overdose deaths, drug-related. We are looking at drug-related deaths; we aren't looking at the murders, we aren't looking at the statistics on children that are put into State and protective care. We don't look at all the other things.

I read the paper the other day. A kid killed somebody and he was on meth. Now, that kid is going to go to jail. Maybe that will get recorded somewhere. The poor person that was killed in the accident is a drug-related death. I will bet you that wasn't counted.

But we need a plan. I would say that you demand that the law enforcement people, starting with the Attorney General, who has said, as you said, this is an epidemic, that we get together.

Have you all sat down? Has DEA sat down with anyone from the Attorney General's, the U.S. attorney's offices, and discussed this issue?

Mr. BURNS. Absolutely.

Mr. MICA. But you don't have a plan?

Mr. BURNS. We do have a plan. Right now between working with ONDCP on the——

Mr. MICA. He doesn't have a plan.

Mr. BURNS. Well, I have a plan if you will let me answer. I am trying to respond to your question, Congressman.

Mr. MICA. You came before this subcommittee and you can't cite or recite to this subcommittee, which is in charge of our national drug policy, what resources are being targeted. You can't even agree on whether this is an epidemic, which the Attorney General or other officers of this administration are saying.

We need a plan. I need to know how much money we need. If you need more resources, this is the subcommittee that can do it. If we need more enforcement tools, we need to change the law. We need to do it now rather than later. This is hell on wheels as far as doing damage to the very basic fabric of our society, so we need a plan.

I need to talk to John Walters. We need to talk to Alberto Gonzales, and we need a plan. We need a summit on this issue immediately and we need people making decisions, getting legislation here, getting you the resources that you need to do the job.

I am not criticizing you. I am just saying, this is something that we have to come together on somewhat in the vein of what you said, but we should have been doing it earlier rather than later.

I yield back, Mr. Chairman.

Mr. SOUDER. Are there any specific recommendations in that book you are waving?

Mr. BURNS. I am sorry?

Mr. SOUDER. My understanding is, there are no specific recommendations in that report?

Mr. BURNS. There are specific recommendations.

Mr. SOUDER. That those are things you are looking at?

Mr. BURNS. Yes.

Mr. SOUDER. But they are not recommendations.

Mr. BURNS. We have two more meetings of the inner working group; and as I mentioned today to the meth subcommittee, after we meet in the intergovernmental arena, we plan to sit down with the meth caucus and with Members and try and come up with a comprehensive plan.

Mr. MICA. Mr. Chairman—see, you know the way this works, they are deciding budgets right now, finances. So if you need money for this, resources, you need to get us the information. We are looking at next year doing this. If you need changes in the law, we need to know now rather than later. Whatever it takes, this needs to be put on an emergency, expedited basis if we are going to get anything done.

We have this little break in here. You should come back before we come back with specific recommendations, with a plan for the education drug money. If you need a supplemental, we will do a supplemental, whatever it takes. This is slaughter on the streets of the United States.

We have identified the problem. It is not Plan Colombia; we have been there, we have done that. It is not designer drugs; we have been there and done that. This is meth popping up everywhere, and we have to get a handle on it. So you guys come up with a plan.

Mr. SOUDER. Mr. Osborne, did you have any comments?

Mr. OSBORNE. Thank you, Mr. Chairman. I just have a comment. Obviously there is a little frustration here, and I can——

Mr. BURNS. I really didn't sense that.

Mr. OSBORNE. And it was building within me as I sat. And, you know, the question was, what one thing would you suggest? And I heard you say, well, we need a comprehensive plan. I guess that is—but it seems like there ought to be more of a rifle shot.

I mean, some of the things that come to mind: Education, there are power points, there are very graphic videos that could be shown to every child in the United States if you wanted to do that. We could target parents, make sure they understood the scope of the problem.

As far as I am concerned, from where I am living, meth currently is the biggest threat to the United States, maybe even including al Qaeda—and I mean that seriously—in terms of the very fabric, the very structure of our Nation. And to have the administration apparently not even be aware of this, that this is the No. 1 drug problem, was really difficult to hear.

A couple other things: Funding, we went from $1 billion for Byrne grants 2 or 3 years ago to $300 million. We have cut it by one-third, and the chairman and others have fought to get a little bit back. But obviously I would think somebody would say, well, we need more money for this, because that is where it interdicts it, on the street, is in the Byrne grants, in the HIDA grants, in the COPS. HIDA has been a fairly level; COPS, we are struggling.

Laws, do we need a national standard? Right now, each State is coming up with a standard, and so what is happening, you are pushing the traffic from one State to another: Where is the toughest State? And then the one that isn't very tough, well, they are going that way.

Do we need a national standard as far as how we handle pseudophed? Do we make it a schedule 5? What do we do? Those are things you could talk about.

What are some of the penalties for the manufacture and sale? Should we make this something like life? Should we make it 30 years? What should we do? We have talked about rehab.

And then last, the precursors. We have introduced—the chairman and others this last week, we introduced an amendment which I think made some sense to target the five largest exporters and importers of pseudophedrine. And what we have said is, OK, if you don't cooperate with the Drug Enforcement Administration and let them know where those shipments are going so we can

track and find the superlabs, then we cutoff your international aid; you don't get any money from the United States.

I didn't hear any comment on that, but we have tried to push you to see. We called, many times, the DEA, my staff and I, over the last 3 or 4 weeks and we tried to say, what can we do? And we couldn't seem to get an answer. So there is frustration here.

And I am sure you are doing the best you can, and we are not trying to throw rocks at you, although I guess we are. But we are saying there is a sense of urgency here, and we need specifics, we don't need generalities at this point.

So I really don't have any further questions. I just wanted to express my feeling of frustration as well as several others up here and from where I am seeing the problem out in the countryside.

And I yield back, Mr. Chairman.

Mr. SOUDER. Thank you. And before wrapping up this panel, I just want to restate a couple of basic points, in that we appreciate all of your service, we appreciate the fact that some things have been done on methamphetamine; and in certain areas, very critical things, such as what we thought at one point was taking down 40 percent of the pseudophedrine company, in the company in Detroit bust, now we find out it wasn't; that what our frustration here is, I have never seen—and all of you know, we couldn't have been more aggressive on the cocaine in Colombia, and heroin, drug-free schools, community grants, drug testing programs.

It is not that I don't believe all that is important. I understand there is nobody on meth who doesn't start on marijuana. Tobacco and alcohol can be gateway to drugs, to many things, but, hey, there is a direct line from marijuana into meth that we are seeing around the country. And I appreciate that difficulty.

What our frustration here is, is that this has been a building pattern moving from west to east. And when it hits a zone, nothing is like it. Now we are seeing it go from rural to small town, and seeing it hit the first cities. And when it hits a city, as the U.S. attorney said in Minneapolis—which is no small town, the Minneapolis size, about a million and a half—it hits. And when it hits that, it changes its form, it just overwhelms a city. On the St. Paul side, the district attorney there said that they went from nothing to 85 percent in 12 months of children under child protection, were all of a sudden under meth. From nothing to 85 percent. Only three mom-and-pop labs in St. Paul.

The rural counties are saying we have mom-and-pop labs, these clandestine labs, but it is a different form of meth that hits the cities. But when it hits, in Omaha, Minneapolis-St. Paul, and a few of those cities are the first big cities hit at the edges of Detroit, edges of New Orleans. And as it marches east, the question is, what is the strategy to stop it?

So what we heard in the budget is—and Mr. Mica's question, what is the prevention program? Well, what we heard was, Safe and Drug-Free Schools isn't working. Well, where is the proposal to make it work? What I would like to hear out of ONDCP is specific suggestions, as the drug oversight office, of how we can improve as we move to redoing No Child Left Behind, which will include Safe and Drug-Free Schools.

We have basically a year and a half; let's figure out how to make this program work. Don't zero it out. It's the only prevention program we've got at the school level. In the National Ad Campaign, what's happening in meth is it's bubbling up. I have never seen in all my years of working in narcotics as a staffer, and now as a Member, something that is coming up from the grass-roots, rather than the people in charge, figuring out how to get ahead of it. We now see the survey at the county level doing it. You see this freelancing among Members of Congress. How do we come up with a Meth Hot Spots program?

It was every year the administration zeroing out, and it gets bigger. It is one of the only programs in this budget thing that it is like the administration says, zero it out. It was at $12 million, it comes back at $18; zero out it, and it comes back at $25. This year it was zeroed out at $32 and it is back at $38. Why? Because members know that the grass-roots of the problem is Meth Hot Spots.

You would think somewhere in that 5-year plan that somebody would have said, you know, this isn't going to go away; maybe we ought to manage it, maybe we ought to figure out where the Meth Hot Spots programs ought to be, rather than trying to zero it out, if the Members of Congress are going to put it in.

And it is even the leadership of both sides of the House right now. This started as a Member bottom-up attack, basically, on the appropriations bills and the authorizing bills because we couldn't get a meth week, we could get the bills through.

So what we did in a bipartisan way is, we sat down together and said, we are going to make every week a meth week until somebody figures this out, and every single bill that comes through this floor every single week we are going to attach meth amendments until somebody comes up with a strategy.

This isn't the way you tackle narcotics. And I hope that each agency is figuring out that this isn't going to stop. We are just going to keep it up until somebody comes up with a strategy. And it will be a hit-or-miss, random type of thing that the people in charge of coming up with a strategy need to say, what do we need to do interdiction internationally? What do we need to do in law enforcement? What do we need to do for children? What do we need to do in prevention?

And say, OK, now let us prioritize this: What do we do to get ahead of the curve rather than chase behind it? And that that report, good as it is—our staffs have gone through it—the group is still working on drafting things even though we are 6 to 8 years into this pattern of steady marching, lack of stabilizing the rural areas, move to small town, and now starting to move into urban areas.

How many years do we have to see the same pattern at an increasing rate in the United States until there is something where we have concrete recommendations, not another cotton-pickin' meeting, and that it needs to move in that direction. I believe you are getting the message.

I agree with Director Tandy that we have to get in and look at the systems that are bringing this in, because we need to hear from the administration that they support Chairman Boehlert's bill on cleanup and that we can do that.

How do we move this Kentucky program into a larger scale so we don't overwhelm the locals? What can we do in the child endangerment question and understand that, look, local officials are dealing with this stuff, but to get it in a systematic way in each of your departments as they are tackling the many things and narcotics efforts that they are doing. And we applaud their efforts.

At the same time, what this is, is if you can't get on top of it and make this a crash program, it is going to be micromanaged with lots of different pieces, without a strategy. And that is what is happening.

And it is going to continue happening, and this committee is trying desperately to say, lead. You are the executive branch. You are doing this day to day. You have agents in the field. Because the way you do this is not having us do random amendments coming up, but we couldn't figure out any other way to do it.

Any comments?

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. I will just be very brief.

When you are sitting here in the Congress and you often—I think meaningful life is one way one's self has constant self-examination and where one tries to figure out if what one is doing is being effective and efficient.

And I have to tell you, as I sit here, I couldn't help but wonder whether this is effective and efficient, because it seems as if on both sides of the aisle we all agree that we have a very urgent situation.

Many years ago people thought that they had an urgent situation in the inner cities. Now, in Baltimore, there are 250-plus murders in a population of less than 650,000 every year. There would be many, many more if we did not have one of the best shock trauma centers in the world. That doesn't even go to all of the hospital admissions, it doesn't go to all the children being left behind, it doesn't go to the AIDS that is spreading through needles.

And I guess what I am saying is that in some kind of way we have to be effective and efficient. We really do. While I—you know, I think that we have to really protect ourselves against terrorist attacks and things of that nature. I am telling you, what I said a little bit earlier, I meant it; we have terrorists in our own houses. And until we get a comprehensive plan and actually execute that plan, we are going to be saying the same things over and over again 10 years from now, only the problem is going to be 30 times greater.

And so I would beg you—I would ask, but asking is too cheap, because there is some little child right now who is going without a parent; there is somebody probably in high school who is thinking about going on a date with somebody on Saturday night, where they are going to be introduced to this stuff, and it is going to ruin them for the rest of their lives. And while we are talking and while we are bickering and trying to figure this out, folks are going to suffer.

So that is why I am just so glad that the word "urgency" has been used here. I don't want the Nation to be an area with a population of 650,000 and 250-plus murders. And you know what hap-

pens? There comes a point in time when you begin to celebrate the fact that you didn't get up to 300 murders. That is deep.

And so it is that I hope you all will listen, and listen carefully—particularly you, Mr. Burns—and will take back that message of urgency. It is not enough to say, we are still getting it together. People are dying and suffering, and generations are being created. New generational cycles are being created, like Ms. Birkmeyer said. And when we are dancing with the angels, there will be people who are suffering for what we didn't do under our watch.

Mr. SOUDER. Ms. Foxx, did you have a comment?

Ms. FOXX. Well, I just wanted to say that I really appreciate what the chairman and the ranking member have said, and the comments from Representative Mica and Representative Osborne. I have been very disappointed in the responses that we received today, too, so much so I wasn't sure how to respond to you all.

But I think that we have to say to you, stop traveling so much, stop having summits, and do a little work on the issue that we brought to your attention.

I think the chairman is very right. You can either give some leadership to this, or you can see the Congress micromanaging what you are trying to do. And I would love, frankly, to see a schedule of the trips and how much money has been spent on it, and then see what results you got from it; because I think everything you do should be giving you some results, and we are not hearing that at all.

Mr. SOUDER. Thank you. And I do want to say something I said earlier. And I know Mr. Burns has raised some of these questions internally, and hopefully we just strengthened your hand in working with the State and locals. But we want the message to go back clearly to ONDCP: You have to lead.

DEA has attempted this, a little bit different type of a thing for DEA to tackle, but you have been at the grassroots level doing it. We need to figure out how now to have a look at what you have been doing at the grassroots level and say, look, how can we do this systematically rather than each HIDTA coming up with a strategy, each DEA task force.

In my area, the DEA leads the task force, and they are obviously having to deal with meth cases. How can we figure out, like we do on cocaine and heroin, how to do this systemically? And I look forward to working with you.

And thank you for bringing the attention to the children question, because often, as we are looking at the law enforcement question, we forget that, A, you lock up the parents, what happens to the kids? And how do we deal with this? I think, like crack babies, we will find that the kids are pretty resilient if we can get to them and get them out of the house and protect them while we get their parents dried out and back functioning as parents.

I thank this panel. I look forward to continuing to work with each of you.

Would the second panel please come forward.

Dr. Nancy Young, Director of the National Center for Substance Abuse and Children Welfare, and Director of the Children and Family Futures; Valerie Brown, National Association of Counties; Freida Baker, Deputy Director of Family and Children's Services,

Alabama Department of Human Resources; Chief Deputy Phil Byers, Rutherford County Sheriff's Office of North Carolina; Sylvia Deporto, Deputy Director of the Riverside County Children's Services of California; Betsy Dunn, Investigator, Peer Supervisor, Tennessee Department of Children's Services, Child Protective Services Division; Chief Don Owens, Titusville Police Department, Pennsylvania; and Sheriff Mark Shook, Watauga County Sheriff's Department, North Carolina.

Before you sit down, if you will find your places and stand. I will swear each of you in.

[Witnesses sworn.]

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

And, Ms. Foxx, would you like to welcome your North Carolina sheriff and friend again?

Ms. FOXX. I would. We are really very pleased to have Sheriff Mark Shook from Watauga County with us here. As I stated in my comments earlier, I have known Sheriff Shook all his life. That is an unfortunate comment on my age. But his family and my husband's family, particularly, have grown up together for a long time.

Mark has done remarkably well as a law enforcement officer in Watauga County, and we are so fortunate to have him as Sheriff. His family is still my neighbor, and they are doing a great job, and we are very pleased to have him. This is his first trip to D.C., by the way, so he sort of had a trial by fire on his first trip.

Mr. SOUDER. Mr. McHenry, do you want to introduce your Sheriff?

Mr. MCHENRY. Thank you, Mr. Chairman.

I am pleased today to have the Rutherford County Chief Deputy Sheriff, Philip Byers, here today. Philip is a man that has great experience. Though a constituent of mine in Rutherford County, he actually went to school in your district, Congresswoman Foxx, at Appalachian State University. That is where he got his B.S., and he also attended Western Carolina and obtained his Master's in public administration there.

He is a man who loves education. As a former teacher and a business owner, he is still very involved in that field, both volunteering in Rutherford County as well as his duty with the Sheriff's Department. He has had 14 years of law enforcement experience, and 4 years of that as the Chief Deputy in Rutherford County.

And Rutherford County is an area that has tackled severe methamphetamine problems over the last few years, and it has the second leading number of meth labs of any county in North Carolina. And the reason why I believe the number is so high is not only because of the issues that we are dealing with in Rutherford County, but because of the good work of the Sheriff's Department there to root out these meth labs. Just last week they busted their 13th meth lab this year.

And so I appreciate the hard work of Phil.

I certainly appreciate him traveling to Washington, DC, with his new wife, Sheila, and I thank you both for being here.

And it is Philip's first time testifying before Congress, so, Mr. Chairman, I just ask you to go easy on him. But if you don't go easy on him, I am sure he can hold his own.

Thank you, Mr. Chairman.

Mr. SOUDER. And I take it you didn't know him as he grew up?

Mr. MCHENRY. I did not. Maybe he knew me.

Mr. SOUDER. And I hope we didn't scare you off with the first panel.

I thank each of you for coming today. I would like to yield to Dr. Young for her statement.

STATEMENTS OF NANCY K. YOUNG, Ph.D., DIRECTOR, NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE, AND DIRECTOR, CHILDREN AND FAMILY FUTURES; VALERIE BROWN, NATIONAL ASSOCIATION OF COUNTIES; FREIDA S. BAKER, DEPUTY DIRECTOR, FAMILY AND CHILDREN'S SERVICES, ALABAMA DEPARTMENT OF HUMAN RESOURCES; PHIL BYERS, CHIEF DEPUTY, RUTHERFORD COUNTY, NC, SHERIFF'S OFFICE; SYLVIA DEPORTO, DEPUTY DIRECTOR, RIVERSIDE COUNTY, CA, CHILDREN'S SERVICES; BETSY DUNN, INVESTIGATOR AND PEER SUPERVISOR, TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES, CHILD PROTECTIVE SERVICES DIVISION; DON OWENS, CHIEF, TITUSVILLE, PA, POLICE DEPARTMENT; AND SHERIFF MARK SHOOK, WATAUGA COUNTY, NC, SHERIFF'S DEPARTMENT

STATEMENT OF NANCY K. YOUNG, Ph.D.

Ms. YOUNG. Thank you. Good afternoon, Chairman Souder, members of the committee. Thank you for the opportunity to address you today. As the Director of Children and Family Futures, I direct the National Center on Substance Abuse and Child Welfare. We are funded by the Substance Abuse and Mental Health Services Administration, and also by the Administration on Children, Youth and Families. However, my testimony today are the views of myself and not the Federal agencies.

There are six points that I would like to discuss today that are detailed in my written statement, including a list of suggested actions.

First, to summarize some data about child welfare trends and about who is coming into treatment. Despite the increase in folks accessing methamphetamine treatment, the overall trend in child welfare has continued to decrease since 1999. At this point, the increase of persons seeking treatment for methamphetamine, we have not seen an overall increase in that trend for children coming into care. Details of those data are in the written testimony on page 3 and page 4.

Even in California, with a decade of experience in addressing methamphetamine disorders, the number of kids in care over the past several years has continued to decrease. This contrasts with the cocaine epidemic of the late 1980's and early 1990's in which the foster care population increased by half. The alarming information about who is coming into treatment is about methamphetamine and the dramatic effect it has created with child welfare services in that rural communities have been affected and that

there has been a sharp increase in treatment admissions for women with primary methamphetamine dependence.

Among adolescents in treatment for methamphetamine, the majority are girls. Most disturbing is the upward trend of pregnant women coming to treatment with marijuana dependence and an even higher rate of increase for pregnant women with methamphetamine dependence. About 10 percent of the births in our country are affected by prenatal substance exposure. Page 10 shows a table of drug use by pregnant women. That is about 400,000 infants per year.

My second point is the critical need for child welfare to differentiate between the various types of children affected by methamphetamine. All children of substance abusers are at risk of abuse and neglect. But there are six different ways in which children are affected specifically by methamphetamine use: parents who use; parents who are substance dependent; parents who use during pregnancy—I should say mothers who use during pregnancy; parents who manufacture or cook in the home; parents who traffic methamphetamine; and parents who operate superlabs. The majority of methamphetamine-afflicted children in child welfare are those whose parents abuse or who are methamphetamine dependent.

Risks to children and the interventions for their families vary a great deal based on these different categories, and child welfare is challenged to appropriately screen for these groups. They are challenged to have access to quality assessments and to ensure that families have timely and comprehensive family treatment resources so that they might recover and reunify.

My third point relates to the characteristics of persons needing treatment, especially women. Alarmingly, the majority of women in treatment for methamphetamine who may have also abused or neglected their children were, in fact, abused and neglected themselves as children. One-third of women in treatment for methamphetamine reported childhood sexual abuse.

Here, the challenge for child welfare is twofold: to appropriately engage with mothers who need treatment, as well as to provide significant substance abuse prevention efforts to children currently in care. I currently know of only one State that targets specific prevention efforts at the children in foster care.

Fourth, treatment effectiveness studies—and we have heard it already today—have shown that rates of recovery for methamphetamine use disorders are similar to other drugs of abuse. This message needs to be widely disseminated among child welfare agencies and the public.

Fifth, there are models of effective child welfare and substance abuse services working together. In Sacramento County over the past decade they have implemented six significant system and practice changes. They are seeing dramatic results in their outcomes.

They intervene at the very first court appearance for all parents with substance abuse allegations with a message of hope and recovery. The full text of my testimony gives the details of their outcomes by primary substance on page 18. Parents with methamphetamine dependence are reunifying with their children at

rates similar to parents with alcohol and cocaine dependence, nearly twice the rate of reunifications before their system reforms.

This didn't happen overnight. As I mentioned, they have been working on it for a decade, on the substance abuse and child welfare efforts.

Finally, what can be done? We must remember and learn from the cocaine epidemic and its impact on child welfare. We must not let child removal escalate without effective prevention and treatment in place. We must not let a generation of children be mislabeled. Rather, we must ensure that they receive the early intervention and special education services that they need. As an adoptive parent of two children with these issues, I know first-hand that these other system interventions are critical for biological, foster, and adoptive families to raise these children to reach their full potential.

We must recognize that in many ways we are flying blind on this issue. Child welfare does not routinely collect information about families with substance use disorders, and treatment agencies do not collect data from parents about children who may be at risk of abuse and neglect.

In most States, we are operating on data about prenatal substance exposure that is more than a decade old. The last such study in California was in 1992, and I believe Ms. Watson played a significant role in making that happen. It has not been repeated since that effort.

We need better data from hospitals and the maternal and child health systems on prenatal and at-birth screenings so we can appropriately monitor, intervene, and provide services for families with prenatal substance exposure. We need to continue to invest in better training for child welfare workers so that they can recognize methamphetamine and other substance use disorders. And we must continue to invest in better training for substance abuse treatment agencies to ensure supports are in place for family treatment and interventions for the children.

When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the-art, comprehensive, allows families to be treated together, and most importantly, to meet the intent of the Adoption and Safe Families Act, that those interventions are timely.

I hope that I will get the questions about what would you specifically do, because I have a list. Thank you very much.

Mr. SOUDER. Thank you.

[The prepared statement of Ms. Young follows:]

Statement of

Nancy K. Young, Ph.D.
Director, Children and Family Futures, Inc.
National Center on Substance Abuse and Child Welfare

Before the U.S. House of Representatives
Government Reform Subcommittee on Criminal Justice,
Drug Policy, and Human Resources

Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies

July 26, 2005

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Chairman Souder, Vice Chair McHenry, Ranking Member Cummings and Members of the Committee, thank you for the opportunity to appear before you today to discuss the problem of methamphetamine in America and specifically its effect on child welfare services.

I am the Director of Children and Family Futures, Inc., (CFF) a non-profit policy research firm based in Irvine, California. For the past ten years we have worked on public policy issues regarding children affected by substance use disorders in their families. Our work is primarily focused on children in the welfare and child welfare systems. In addition, in 1994, my husband and I became foster and then adoptive parents to two children who embody many of the issues confronting children of parents with substance use disorders who have been abused or neglected. So, I am also speaking as an adoptive mother of children affected by these issues.

In 2002, CFF was awarded a competitive contract from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to develop and implement the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is funded by both the Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect and SAMHSA and we work with both agencies in that work. However, my testimony today represents my own views and not those of the Federal agencies

There are six points I'd like to discuss today, including a list of suggested actions:

1. A review of data on the impact of parental substance use disorders on child welfare agencies and the specifics that are known about methamphetamine;

2. The various ways that children are affected by parents with substance use disorders;

3. The unique characteristics of methamphetamine users that pose new challenges to child welfare organizations;

4. Data regarding the effectiveness of treatment for women with methamphetamine use disorders;

5. Models of effective child welfare and substance abuse services; and

6. Recommendations for action – what can be done to address these issues

1. The impact of parental substance use disorders on child welfare agencies and the specifics about methamphetamine

As noted in multiple sources, the number of methamphetamine users has increased over the past several years and spread from the West throughout the Midwest, now increasingly reaching the Eastern States. In 2003, according to the National Survey of Drug Use and Health, there were 607,000 persons reporting methamphetamine use in the prior 30 days; methamphetamine users now exceeds the number of current crack users (604,000). However, there remains a much larger number of current cocaine users at 2.281 million.[1]

Despite the number and relatively rapid increase in methamphetamine use across the nation, the population of children in out-of-home care in the country has been on a steady decline since 1999 with 523,000 children in care in 2003. The decrease comes after a decade in which the number of kids in care doubled from 276,000 children in 1985 to a high of 570,000 in 1999.

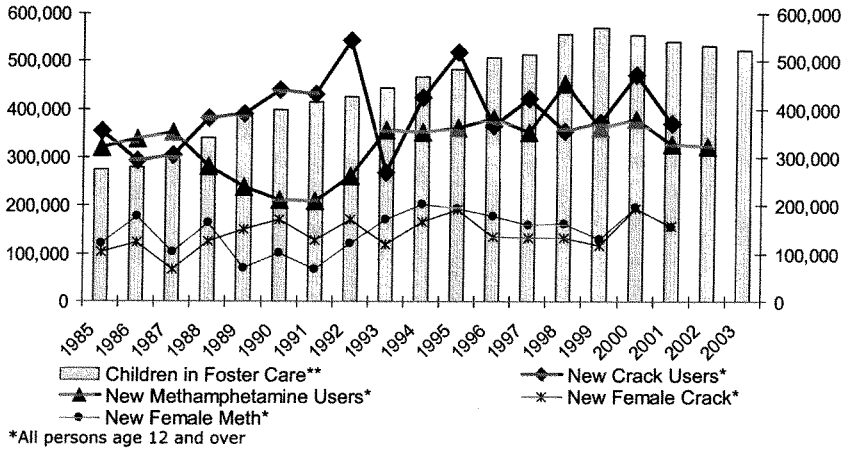
However, there is very little data on the number of children in foster care due to parental substance use disorders. Anecdotal estimates range from 40 to 80%. The Department of Health and Human Services (DHHS) in its Report to Congress in 1999[2] stated that between one-third and two-thirds of children in the child welfare system are affected by substance use disorders.

More recently, DHHS has sponsored the National Study on Child and Adolescent Well-Being (NSCAW) which has collected data on families affected by substance abuse and dependence. Preliminary results found much lower rates of parents needing substance abuse assessments (approximately 25%) and those that were alcohol or drug dependent (about 5%). However, they also found that child welfare workers misclassified parents regarding their need for an assessment and those that were alcohol or drug dependent nearly 80% of the time.[3]

Graph 1 on the following page shows the population of kids in care on September 30 of each year. This is overlaid with the line graphs showing a leading indicator of the cocaine and methamphetamine epidemics—new users of the substance during the year. The number of children in foster care increased by 50% between 1986 and 1992; these are also the peak years of the crack epidemic. Many have attributed this rapid increase of kids in care to the cocaine and crack epidemic of the late 1980s and early 90s.

At this point, we have not seen a similar trend in child welfare caseloads, despite the number of new users of methamphetamine. However, the number of new users who are women is disturbing. This is clearly one of the issues that child welfare has had to address—the large number of women who are using methamphetamine. The issues specific to women and methamphetamine are discussed below.

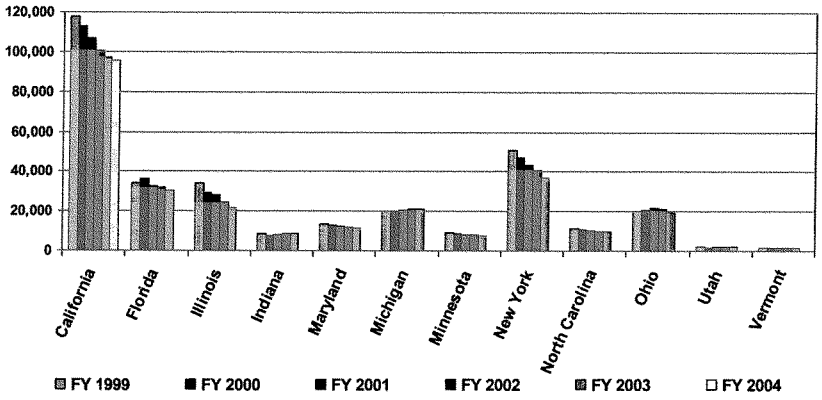
Graph 1: Foster Care Population and Persons Who First Used Crack or Methamphetamine in Prior Year[4]



*All persons age 12 and over

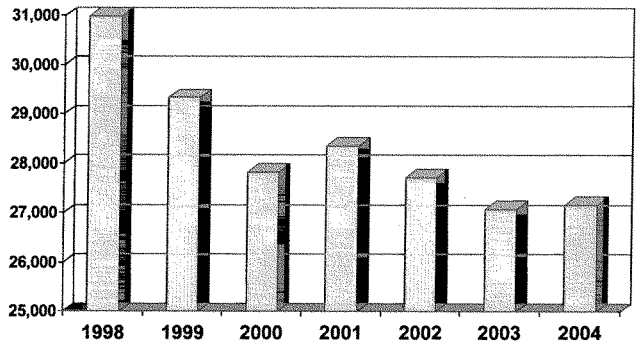
These data show a decrease in the foster care population that is also evident when we look at specific states. Graph 2 shows the last four years of the foster care population in the 12 states that are represented by members of the subcommittee. Of these States, California, Illinois and New York have experienced dramatic reductions in the number of children in out-of-home care. While some of the States may just be beginning to experience the impact of methamphetamine, clearly California has felt the impact of methamphetamine for a decade, and yet they have continued to see an overall reduction in children in care.

Graph 2: Foster Care Population on September 30 of each Fiscal Year in Selected States[5]



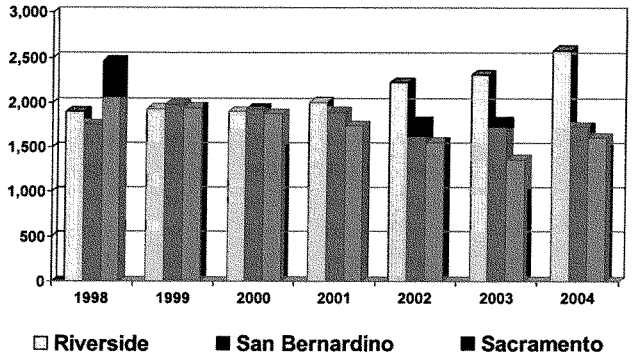
In California, this reduction reflects both fewer children coming into care and more children exiting care over the past six years. Graph 3 shows the decreasing number of children entering care in California (among children who stayed in care for five or more days) with a leveling of that number between 2003 and 2004. So while California has been faced with the increasing number of persons using and dependent on methamphetamine for a decade, through 2004, they have not experienced an overall increase in children being removed from their parents' custody.

Graph 3: Entries to Out-of-Home Care in California[6]



Yet we know that the impact of specific substances and child welfare practice regarding parental substance use can vary greatly from State to State and county to county. For example, Graph 4 shows three California counties that have been discussed in the media as having been particularly affected by methamphetamine production; as the chart shows, they have very different patterns of children entering care.

Graph 4: New Entries to Foster Care: Riverside, San Bernardino and Sacramento Counties[7]



While we haven't seen overall increases in children in out-of-home care, we lack the data to know if there are increases in children who are coming into care affected by substance use, and we do not have data on children specifically affected by methamphetamine. However, the data showing differences at the local level suggest that local child welfare practice plays a role in the number of children entering out-of-home care associated with parental methamphetamine use.

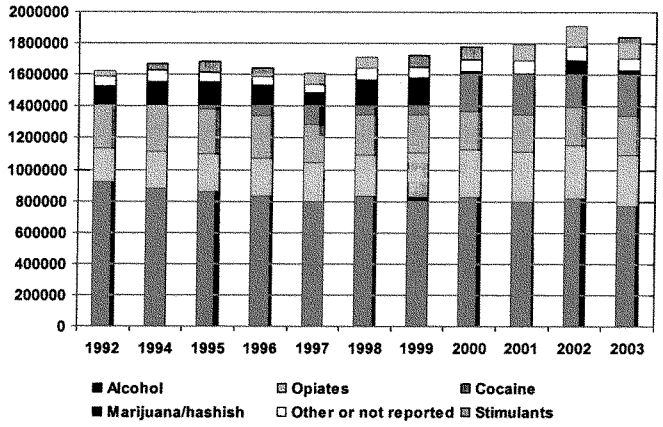
Methamphetamine and Treatment Admissions

Another way to explore these issues is to look at an indicator that would be considered a "lagging" indicator of drug use patterns—those persons entering publicly-funded substance abuse treatment.

Graph 5 shows the number of persons reported by the States entering treatment by primary substance. The data for stimulants (the top of the bar) includes both methamphetamines and other stimulants (other stimulants account for approximately 1% of the admissions). While overall treatment admissions have increased by 14% between 1993 and 2003 (1.618 million to 1.842 million), admissions for person with stimulant disorders increased from 28,900 in 1993 to nearly 137,000 in 2003, a 373% increase.

Just as child welfare has needed to adjust their practices to work with families affected by methamphetamine, substance abuse treatment agencies have needed to adjust to treating methamphetamine users in larger numbers. However, admissions for methamphetamine account for only about 7% of all admissions. Despite the increase in methamphetamine, one might assume that child welfare practitioners are still working with many more families affected by the other substances of abuse, particularly alcohol which accounts for more than 40% of treatment admissions.

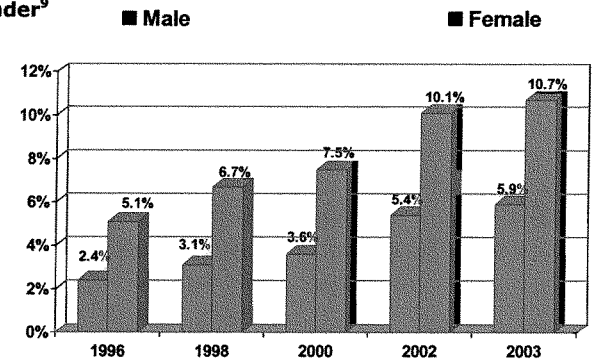
Graph 5: Treatment Admissions by Primary Substance[8]



Methamphetamine Users Differ from Others with Substance Use Disorders

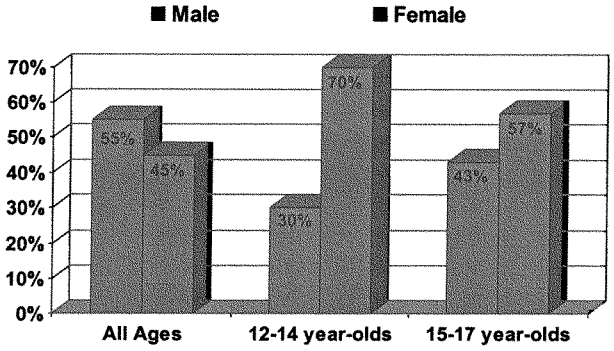
Child welfare unquestionably faces unique characteristics of persons in treatment for methamphetamine. In the nation, women represent about 30% of all treatment admissions. However, women's admissions for methamphetamine are much higher percentage of their overall admissions than for men. Of admissions for methamphetamine related problems, women are just over 10% of their total admissions compared to 6% of admissions for men. Graph 6 shows the treatment admission data by gender.

Graph 6: Percent Methamphetamine/Amphetamine as Primary Substance, By Gender[9]



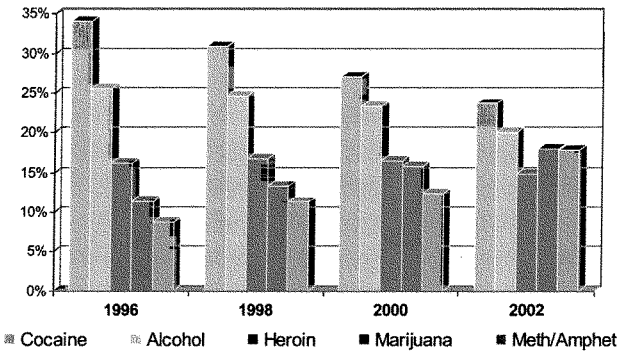
Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents, with girls representing 70% of youth admitted to treatment for methamphetamine between 12 and 14 year olds. Graph 7 shows these data.

Graph 7: 2002 Methamphetamine/Amphetamine Admissions by Gender and Age[10]



Another urgent issue is the change in drug use patterns among pregnant women. Graph 8 shows that among pregnant women entering treatment, there has been a decrease in those reporting cocaine and alcohol-related problems, relative stability in admissions for heroin and an increase of 57% for marijuana and of 105% for pregnant women reporting methamphetamine disorders.

Graph 8: 2002 Treatment Admissions for Pregnant Females by Percent reporting Primary Substance[11]



Summary

The number of children coming into the foster care system has declined over the last half decade. However, child welfare practice and substance use patterns vary from State to State and county to county. While data on the number of children affected specifically by methamphetamine is not available, we know that treatment admissions for methamphetamine are a small yet growing group among those entering treatment in most areas of the country.

The lack of child welfare-specific data on substance use disorders reinforces the long-standing issue that child welfare workers need better protocols for screening, better cross-system linkages to assessments and importantly, better information systems to monitor this type of emerging issue. Our data on this problem are surprisingly sparse, given the importance attached to this issue. The federally mandated child welfare information system produces only optional data on substance abuse or dependence; in many states, this is not a field that is required to be filled out.

As we have seen, the impact of methamphetamine as it affects children and parents in the child welfare system must be compared with the total pattern of drug use and the need for treatment across all legal and illegal drugs that affect children. In the last graph, the rise in methamphetamine is unmistakable, but so is the fact that the total of the other four drugs is far greater than the number of children affected by methamphetamine.

2. Ways in which children are affected by parents with substance use disorders

Children of parents with substance use disorders may experience multiple risks to their safety and well-being. These risks have been well documented and include:

- Chronic neglect
- Chaotic home lives
- Violence associated with drug sales
- Inconsistent parenting
- Entry to foster care and multiple placements
- Incarcerated parent(s)
- May be risk of HIV exposure if parent is a needle user

In addition to these risks, it is particularly important for child welfare to understand the types of parental methamphetamine use that affect children. There are six situations in which children are affected by their parent's involvement in methamphetamine:

- The parent uses or abuses methamphetamine (episodic use)
- The parent is chemically dependent on methamphetamine
- The mother uses methamphetamine while pregnant with the child
- The parent "cooks" methamphetamine in the home
- The parent sells, transports, or distributes methamphetamine (traffickers)
- The parent manufactures large quantities of methamphetamine (superlabs)

While much of the media attention and child welfare training has been focused on parents who "cook" methamphetamine, each situation presents specific risks and dangers for the child and specific concerns for the child welfare worker. As Jay Wurscher, the substance abuse program manager for the Oregon Department of Children and Families, stated, "The Oregon workers started out being trained, largely by the criminal justice system, to address issues related to methamphetamine manufacturing. What they found over time was that workers had to be much more prepared to work with families with methamphetamine abuse and dependence and that the number of times that workers confronted actual manufacturing was rare in their practice compared to the number of families affected by methamphetamine abuse and dependence."[12] Each separate situation confronting child welfare in their need to differentiate the risk to children is discussed below.

Parents Who Use or Abuse Methamphetamine

Episodic parental use or abuse of methamphetamine is the most common means by which children are affected by parental methamphetamine use. This method of exposure accounts for the highest number of children exposed to methamphetamine, compared to the numbers found in the other categories.

Similar to parents who abuse other substances, particularly stimulants such as cocaine, parents under the influence of methamphetamine pose a danger to their children. When "high," the parent may exhibit poor judgment, confusion, irritability, paranoia, and increased violence; they may fail to provide adequate supervision. Even during periods in which the parent may not be actively under the influence, the family and social environment may be inadequate, and the children may be at risk of abuse and neglect due to the family dynamics associated with substance use.

In households where a family member smokes the substance, children may be exposed to secondhand methamphetamine smoke. They may accidentally ingest the substance if it is kept in the home.

Because methamphetamine users typically use other substances at the same time, including alcohol, tobacco, and other drugs, the risks to their children accumulate, and it becomes difficult to attribute a particular effect to a particular substance.

Dependent Parents

When the parent is substance dependent, meaning they meet criteria for a diagnosis of substance dependence rather than a substance abuser or user, chronic neglect of the children becomes more likely, and the family and social environment is more likely to be inadequate. The children are exposed to the drug-affected parent more frequently and for longer periods of time. They may be living in inadequate conditions, lacking food, water, gas, and electricity. They may lack medical care, dental care, and immunizations. These children are also at greater risk of abuse. Some researchers have found persons with methamphetamine dependence to have an increased association of drug use and high risk sexual behaviors[13] which may place children at higher risk of childhood sexual abuse than children of parents with other substance use disorders.

Prenatal Exposure

Many studies of the effects of prenatal substance exposure compare methamphetamine-exposed infants to non-exposed infants without also comparing them to cocaine-exposed or other stimulant-exposed infants, so it is not known whether the effects are associated with methamphetamine in particular or with all stimulants.

The direct (when chemicals enter the fetus' blood system) and indirect effects (the decrease in blood flow to the fetus as a result of decreased blood from the mother)[14] of substances, including the legal drugs, tobacco and alcohol, can cause birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders. Methamphetamine and other stimulants jeopardize the development of the fetal brain and other organs.[15] As was previously found with crack cocaine exposure, a high dose of methamphetamine taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus, which can lead to stroke or brain hemorrhage.[16] Prenatal stimulant exposure has

been associated with difficulty sucking and swallowing, and hypersensitivity to touch after birth.[17]

Stimulant-exposed children are often affected by other substances used by the mother, and by environmental risk factors such as the mother's nutritional and health status. The cumulative effects of the use of multiple substances and other environmental risk factors have significant adverse effects on the newborn. These effects may be greater than the effects of stimulant use alone.[18] Substances such as alcohol have severe long-term effects on prenatally-exposed children. Children with Fetal Alcohol Spectrum Disorders (FASD) exhibit a range of central nervous system effects, including mental retardation;[19] hyperactivity and attention deficits;[20] poor impulse control; perceptual and motor problems;[21] expressive language delays;[22] delayed motor development;[23] poor listening skills;[24] poor abstract thinking skills; poor problem-solving skills; poor social adaptation; and deficits in attention and memory.[25]

Thus the most significant forms of substance use during pregnancy may be the use of alcohol and tobacco, given the total number of children affected, the severe central nervous system impairments that can result from alcohol exposure, and the low birth weight associated with smoking. Many of the central nervous system-related disorders are determined in the first trimester of pregnancy. Recent surveys indicate that far too many women are using substances during the early months of pregnancy. Table 1 shows the percentage of pregnant women reporting substance use. The number of infants is derived from that percentage and the 4.1 million annual births in the country.* Clearly the message regarding alcohol use and pregnancy has reached women with substantial declines in binge alcohol use by the third trimester. Yet there is a continuing urgency to reduce substance use during pregnancy, particularly in the first trimester.

Table 1: Substance Use during Pregnancy[26]

Substance Used (Past Month)	**1st Trimester**	**2nd Trimester**	**3rd Trimester**
Any Illicit Drug	7.7% women 315,161 infants	3.2% women 130,976 infants	2.3% women 94,139 infants
Alcohol Use	19.6% women 802,228 infants	6.1% women 249,673 infants	4.7% women 192,371 infants
Binge Alcohol Use	10.9% women 446,137 infants	1.4% women 57,302 infants	0.7% women 28,651 infants

It seems critical to do rapid, in-depth studies at several key points throughout the nation, including prevalence studies in hospitals that can be done with random screening, as Idaho, Hawaii, and Monterey County, California have done in recent

* Note: for purposes of this paper, it is assumed that the pattern of drug use among all pregnant women is the same as among those who actually gave births to live children, although live births were 63.4% of all pregnancies in 2000, due to miscarriages and terminations.

years. This would add to our total store of information on the drugs of choice of parents who prenatally expose their infants to harmful substances. These studies have not been done nationally and *the last representative State-level study monitoring prenatal substance exposure was in California in 1992*.

Home Labs

Some parents produce quantities of methamphetamine in their homes for their own use or small-scale distribution, as compared with the superlabs where large-scale production occurs. Children in these homes are subject to the same risks noted in the sections on parents who use/abuse and are dependent on the drug, but they have additional risks associated with the substances used in the production of methamphetamine and the method of production. The children may be exposed to toxic chemicals, contaminated food, fumes released during the "cooking" process, and the danger of fire or explosion from the manufacturing process.

The risks to children and to "first responders" including child welfare workers in homes where methamphetamine is produced have been well documented. These risks include toxic chemical exposure. Children are more likely than adults to suffer health effects from exposure to chemicals. They have higher metabolic rates; their skeletal systems and nervous systems are developing; their skin is not as thick as an adult's skin, which means they absorb chemicals faster; and children tend to put things in their mouths and use touch to explore the world. Some fumes or gases are heavier than air, and will sink down to the child's level, increasing their exposure. Children also tend to imitate adult behavior and are vulnerable in chaotic and unsafe environments.[27] A review by Kolecki[28] revealed that pediatric patients with methamphetamine poisoning exhibited rapid heartbeat, agitation, inconsolable crying, irritability, and vomiting.

Trafficking

Parents who traffic in methamphetamine by selling, transporting, or distributing it, expose their children to an increased risk of violence and abuse. There may be weapons in the home. The parent's associates or customers may carry weapons, putting the children at risk for violence. These children are also at increased risk of physical and sexual abuse by those who visit the home.

Superlabs

Superlabs are methamphetamine laboratories where methamphetamine is produced on a large scale (estimated at 10 pounds per day). Children are sometimes found in these superlabs, but they are less likely to be present in superlabs than in the homes where smaller quantities are produced.

Number of Children in Methamphetamine Homes

Table 2 shows the number of children reported to be involved where methamphetamine was being manufactured.

Table 2: Children Affected in Methamphetamine Manufacturing[29]

	2000	2001	2002	2003	Cumulative Total
Number of Incidents	8,971	13,270	15,353	14,260	51,854
Incidents with children present	1,803	2,191	2,077	1,442	7,513
Children residing in labs	216	976	2,023	1,447	4,662
Children affected**	1,803	2,191	3,167	3,419	10,580
Children exposed to toxic chemicals	345	788	1,373	1,291	3,797
Children taken into protective custody	353	778	1,026	724	2,881
Children injured	12	14	26	44	96
Children killed	3	0	2	3	8

*The 2003 figure for the number of incidents is calendar year, while the remaining data in the column are for fiscal year; **Data for 2000 and 2001 may not show all children affected

Between 2000 and 2003, more than 10,000 children have been affected by methamphetamine manufacturing. These figures are probably underreported, since many states do not keep records on children present at laboratory sites, nor do they medically evaluate the children for the presence of drugs or chemicals. While these children are critical, it is important for child welfare to consider these numbers in the context of the much larger number of children entering child welfare services affected by parental substance use disorders. As shown above in Graph 1, there are over 500,000 children in out-of-home care and approximately 250,000 children enter care each year. *During the four year period in which 10,000 children were reported as affected by methamphetamine, 1 million children entered out-of-home care.*

Summary

Children are affected by parental methamphetamine use in a variety of ways. Clearly more children are affected by parents who use, abuse and are dependent on methamphetamine than those who might be affected by manufacturing activities. However, it is important for child welfare workers to understand which group of children they are working with and to include screening and assessment for substance use in the child risk and safety assessments. It is a sad reality, as borne out by some of this data, that screening and assessment practices are still inadequate to detect most of the prenatal and post-natal substance use affecting children in the child welfare system.

It is also critical, given these effects on children, to take seriously the new requirement in the 2003 amendments to the Child Abuse Prevention and Treatment Act that require all substantiated child abuse and neglect be reported to the local agencies responsible for the Individuals with Disabilities Education Act (IDEA). Developmental delays and disabilities resulting from these prenatal and post-natal effects must be the focus of the earliest possible interventions, since we have extensive evidence that early intervention can address some of the most serious of these developmental effects.

3. The unique characteristics of methamphetamine users that pose new challenges to child welfare organizations

To provide a perspective on challenges facing child welfare regarding methamphetamine use, it is helpful to compare methamphetamine users with the users of cocaine, another stimulant that has been a child welfare issue for the past two decades. Compared with cocaine users, methamphetamine users:

- Begin using substances at a younger age[30]
- Enter treatment at a younger age[31]
- Are more likely to use multiple drugs (especially marijuana)[32]
- Have a higher frequency of use[33]
- Are less likely to use alcohol[34]
- Report feeling less "addicted" than cocaine users[35]
- Are more likely to use methamphetamine continuously throughout the day at evenly spaced intervals and consistently over time, rather than concentrating use in the evening as cocaine users tend to do[36]
- Use fewer times per day than cocaine users (though the same amount of drug is used)[37]
- Spend less money to purchase the drug[38]
- Are more likely to be female and Caucasian[39]

In addition, several sources have documented the rural nature of methamphetamine use.[40] While over 20 million Americans who needed treatment for substance use disorders in 2003 did not receive it, access to treatment resources in rural communities is a critical issue for child welfare practice.

Women Methamphetamine Users

Of the total number of individuals admitted to treatment for methamphetamine, 47% are women. This percentage of female admissions is higher than the percentage of female admissions associated with any other drug except tranquilizers.[41] The implication is that more children are likely to be affected by a parent's use of methamphetamine than if users were predominantly male, since caretakers are often predominately female.

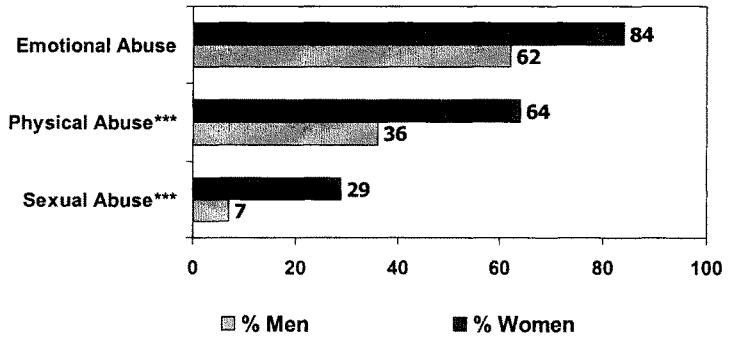
Compared with male methamphetamine users, female methamphetamine users:

- Use methamphetamine more days in a 30-day period[42]
- Smoke rather than snort or inject the drug[43]
- Are more likely to be single parents who live alone with their children[44]
- Have worse medical, psychiatric, and employment profiles[45]

These statistics indicate a greater risk for the children of mothers who use methamphetamine. The parent is likely to use the drug more often and have greater difficulty providing adequate parenting and economic support for the child.

Methamphetamine users, like other drug users, are more likely than non-users to have experienced physical or sexual abuse as children. A recent study of clients of a publicly-funded treatment system found that two-thirds of women methamphetamine users had been physically abused and nearly one-third had been sexually abused. The women were victims of this abuse at a very young age with 43% reporting that sexual abuse occurred before the age of 10 and a similar percentage reported childhood physical abuse.[46] The data on types of childhood abuse are shown in Graph 9.

Graph 9: Childhood Abuse among Adult Methamphetamine Clients in Treatment



***** significant difference between women and men p < .001**

This information has crucial impact on child welfare. First, the majority of women that are mothers of children in care may have significant co-occurring mental disorders associated with their childhood abuse, including a high degree of post-traumatic stress associated with this childhood trauma. Second, these data point to the critical need for substance abuse prevention programming targeted to the children who are victims of child abuse and are in the child welfare system today.

The issues specific to women methamphetamine users also suggest a further need for training of child welfare workers in effective treatment engagement strategies, for improved screening and assessment, for child welfare information systems and drug treatment admission information systems to both be upgraded to capture this information, and a need for expanded outreach to rural areas, using formal and informal means of providing services to rural areas.

4. Information regarding the effectiveness of treatment for women with methamphetamine use disorders

Despite these complex clinical issues and co-occurring disorders among women with methamphetamine dependence, studies have shown that treatment for methamphetamine can effective. As the committee is aware, the University of California at Los Angeles, Integrated Substance Abuse Program has conducted extensive research on treatment for methamphetamine. They have found that outcomes have not differed from other drugs of abuse treatment studies.

Positive treatment outcomes were achieved using:

- Intensive outpatient setting
- Three to five visits per week of comprehensive counseling for at least the first three months
- Cognitive behavioral approaches
- Contingency management
- Reducing consequences associated with drug use such as the need for health care, employment services and mental disorders
- Motivational interviewing & brief intervention models
- Intervening earlier and reducing cumulative harm
- Attending to co-occurring mental disorders.

Brecht[47] has analyzed the treatment effectiveness data from UCLA specifically to document treatment outcomes for women. She found positive outcomes regarding substance use among women in treatment and outcomes that are comparable to other substances of abuse. For every 10 women entering treatment, 6 were continuously abstinent for 1 month; 4 were continuously abstinent for 12 months; 3 were continuously abstinent for 24 months and 3 continued to be abstinent at 48 months. This standard is a fairly high standard to meet—continuous abstinence for 48 months.

5. Models of effective child welfare and substance abuse services

Counties and States around the country have begun the hard work of providing comprehensive programs and system reforms to better address the issue of substance use among families in child welfare. For example, positive outcomes regarding methamphetamine dependence among parents in child welfare have been documented in Sacramento County. Over the past decade, Sacramento has instituted six critical system changes in child welfare and treatment practices for parents with substance use disorders. The system changes require a comprehensive view of the county's response to substance use disorders among families in child welfare. Sacramento's system changes include:

1. **Comprehensive training—**to ensure that all workers in the Department of Health and Human Services fully understand substance abuse and dependence and are trained with skills to intervene with parents

2. **Early Intervention Specialists—**Social workers trained in motivational enhancement therapy are stationed at the family court to intervene and conduct preliminary assessments with *ALL* parents with substance abuse allegations at the very first court hearing in the case

3. **Improvements in Cross-System Information Systems**—to ensure that communication across systems and methods to monitor outcomes are in place as well as management of the county's treatment capacity

4. **Prioritization of Families in Child Protective Services**—County-wide policy to ensure that families in the child welfare system have priority access to substance abuse treatment services

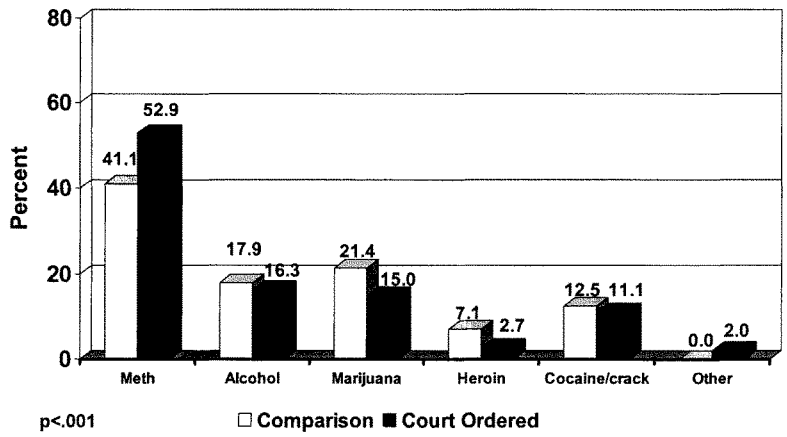
5. **Specialized Treatment and Recovery Services (STARS)**—provides immediate access to substance abuse assessment and engagement strategies conducted by staff trained in motivational enhancement therapy. STARS provides intensive management of the recovery aspect of the child welfare case plan and routine monitoring and feedback to CPS and the court

6. **Dependency Drug Court**—provides a system of more frequent court appearances for *ALL* parents with allegations of substance use with immediate rewards and sanctions based on compliance with court orders regarding the recovery plan.

These strategies have produced dramatic reductions in the time that children spend in out-of-home care and cost savings to the county. There are over 900 parents and 1500 children included in the treatment group of evaluation data. At 18 months after the child welfare case opened, 44% of parents had reunified with their children compared to 25% of the comparison group. Of the reunified families, on average the comparison group reunified in 300 days and the treatment group reunified in 257 days—cutting nearly two months in costs of out-of-home care.

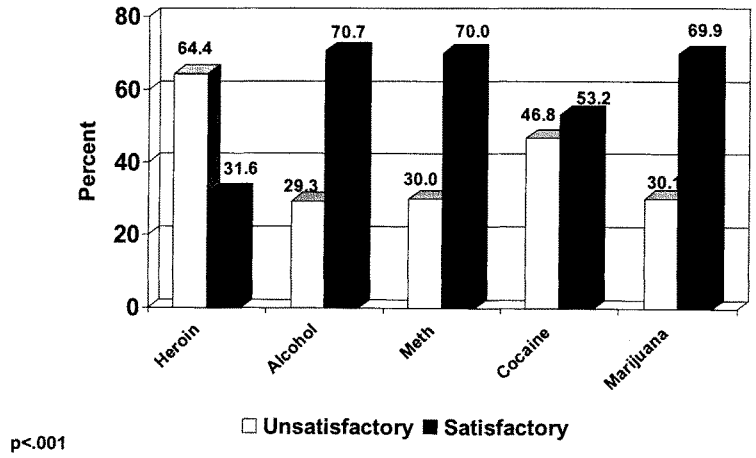
Graph 10 shows the primary substance for two groups of people in treatment, those who were court-ordered and a comparison group who were not court-ordered.

Graph 10: Primary Drug Problem



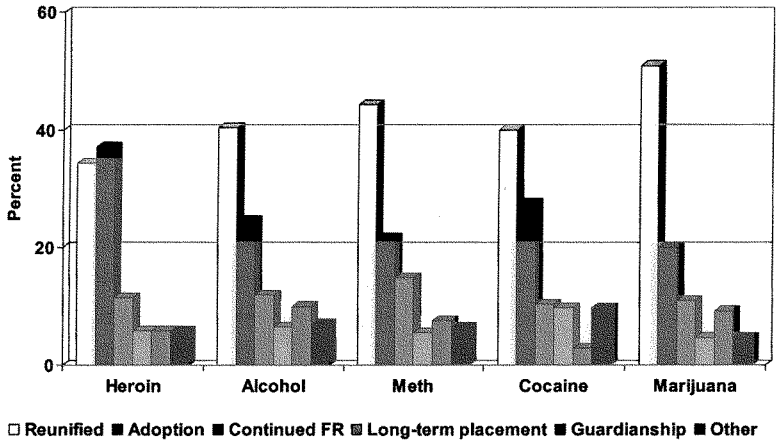
Positive treatment outcomes have been achieved across groups of drug users as shown in Graph 11.

Graph 11: Treatment Discharge Status by Primary Drug Problem



Finally, outcomes related to child permanency have not varied by the type of substance used by the parent as shown in Graph 12. At 18 months after the child was placed in protective custody, there was no statistical difference between child placement and parent's primary drug problem. Parents with a primary heroin problem had more children who were adopted than had reunified, however. These outcome data include comparison, court-ordered year 1 and 2 cohorts for a total number of participants of 1,063.

Graph 12: 18-Month Child Placement Outcomes by Parent Primary Drug Problem



6. What can be done to address these issues?

The National Center on Substance Abuse and Child Welfare assists States and communities in their efforts to address these issues. We provide guidance for States and communities regarding methamphetamine and child welfare practices, including measuring risk and safety factors for children and child welfare workers who make home visits. We have developed a white paper on methamphetamine and women's and children's issues that is the basis for our guidance to States. We recently presented a 90-minute teleconference on the implications of methamphetamine for child welfare that was attended by grantees of the Children's Bureau System of Care Program, including Federal officials and child welfare workers from around the country. We sponsored "Women, Children, and Methamphetamine, a plenary session at the NASADAD annual conference in June of 2005; we have responded to 30 requests for technical assistance on this issue from national, regional, State, and local jurisdictions; and we compiled a list of internet-accessible resources on methamphetamine and child welfare that is available on the

Children and Family Futures website at www.cffutures.org. Our efforts continue, but there is a tremendous amount of work that must be done.

Our recommendations, made throughout this testimony, are not complicated:

- We must have better information on methamphetamine use from both the treatment and child welfare systems—and the two systems need to put their information together so we know about parents and caretakers who are in both systems

- We need better data from hospitals and the maternal and child health systems on the prenatal and at-birth screening they are doing

- We need to continue to invest in better training for child welfare workers so that they can recognize the problems of methamphetamine use among families and ensure timely access to services

- We need earlier diagnosis and intervention with children affected by prenatal and post-natal effects of methamphetamine

- When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the-art, comprehensive, and most importantly to meet the intent of the Adoption and Safe Families Act, interventions must be timely.

Unfortunately, there is all too much that we can learn from the crack and cocaine epidemic experiences of child welfare of the late 1980s and early 1990s. We over-generalized about the problem, and we stigmatized the children involved greatly beyond what we learned they were actually experiencing as a result of prenatal exposure. The phrase "crack babies" was the subject of far too many school workshops that frightened teachers into worrying that these children simply "could not learn." We should not repeat the same mistake with a generation of mis-labeled children who are pre-natally exposed to methamphetamine.

We must, as noted in my testimony, realize how big the methamphetamine problem is—and how big the larger problem is that includes all children and families affected by all forms of substance abuse and dependence, both legal and illegal. Your colleagues in the Congressional caucus on fetal alcohol spectrum disorders have made a large contribution to our understanding of the full range of substance use disorders, and we need to keep that broad perspective in view.[48]

The methamphetamine crisis unquestionably raises new challenges to the child welfare system, and child welfare workers need and deserve help in responding to it. But at the same time, this should not come at the expense of other efforts to help families and communities to deal with the effects of legal and illegal drugs on their children. Helping families and protecting children is not a zero-sum game, in which we must take away from one effort to fund another.

When we worry about our national security, we add resources, and we change our daily routines at airports and in subways, in the interests of security. That is the right thing to do. We don't stop funding the military; we add funding for homeland security as well. The security of thousands of children needs a similarly additive perspective to ensure that timely access to services for parents' recovery and children's safety and well-being can be assured. We can do more, and so we must.

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Mr. SOUDER. Ms. Brown.

STATEMENT OF VALERIE BROWN

Ms. BROWN. Thank you, Mr. Chairman and Ranking Member Cummings, for allowing me to appear this afternoon on behalf of the National Association of Counties on this critical issue of methamphetamine abuse. My name is Valerie Brown, and I am a county supervisor from Sonoma County, CA. That would be Congresswoman Watson's California.

The National Association of Counties [NACo], is the only national organization that represents county governments. With over 2,000 member counties, we represent over 85 percent of the Nation's population.

A growing issue for NACo counties is methamphetamine abuse. Methamphetamine, or meth, is consuming a greater share of county resources because of its devastating and addictive nature. For Congressman Mica, I will boldly tell you, counties need more money. In many parts of the Nation, county jails are becoming overwhelmed with inmates on meth-related charges. Investigating and busting meth labs is producing longer hours for county law enforcement. Along with these law enforcement consequences, meth treatment, cleanup, and removing children from meth houses are all painful reminders of a community dealing with meth.

Because of the need for data, NACo commissioned two surveys on the meth epidemic, and I would like to make three key points on these surveys and NACo's policy on meth.

First, as our survey confirmed, methamphetamine abuse is a national drug crisis that requires national leadership.

Second, a comprehensive, intergovernmental approach is needed to combat the methamphetamine epidemic. Necessary components must include law enforcement, treatment, prevention, education, public health, cleanup, research, and restricting the sale of pseudophedrine.

Third, existing programs such as the Justice Assistance Grant Program, foster care, and mental health and substance abuse programs are critical to the fight against the devastating effects of methamphetamine.

To elaborate, I will touch on NACo's survey on law enforcement. In the 500 responding sheriffs' departments, 87 percent report increases in meth-related arrests starting 3 years ago. Mr. Chairman, two of the States that reported 100 percent increases in meth-related arrests during the last 3 years are your State of Indiana and my home State of California.

Additionally, 58 percent of county law enforcement agencies reported that meth is their largest drug problem. Meth outpaced cocaine at 19 percent, marijuana at 17 percent, and heroin at 3 percent.

Meth-related arrests represent a high proportion of crimes requiring incarceration. Fifty percent of the counties estimated that one in five of their current jail inmates are there because of meth-related crimes.

In Orange County, CA, of the 11,500 new probation cases each year, 60 percent test positive for meth. In my home county, the

sheriff's department estimates that 85 to 90 percent of our drug arrests are related to methamphetamine.

Numbers are increasing so rapidly, counties are having a difficult time ramping up our services to address the problem.

We surveyed child welfare officials from the 13 States where services are provided at the county level. Children living in environments where meth is produced are considered drug endangered due to toxins, neglect, and abuse. Forty percent of all the child welfare officials in the survey reported increased out-of-home placements because of meth in the last year.

During the past 5 years, 71 percent of the responding counties in my home State of California reported an increase in out-of-home placements. The Midwest reported similar findings, with 69 percent in Minnesota and 54 percent in North Dakota.

In addition, 59 percent of county officials reported meth has increased the difficulty of reuniting families. An ER physician, who also serves as county commissioner, stated at our recent annual conference that a premature baby born to a meth-addicted mother costs approximately $1 million before the infant leaves the neonatal center. His center currently houses three drug-addicted babies.

NACo believes that these figures confirm the need for a comprehensive and intergovernmental strategy to fight this insidious drug. A multidisciplinary approach has proven effective in several communities that have been facing this drug for many years.

One such program is in Pierce County, WA, where a social worker accompanies law enforcement officials to meth busts to assess the effects of that environment on the children present. This level of cooperation starts at the top, as Pierce County Sheriff Paul Pastor recently stressed at a NACo meeting. Fighting methamphetamine in our communities requires a team-oriented approach with all departments, which is very costly for counties.

Last, I would like to make an appeal for some existing Federal resources. One critical program is the Justice Assistance Grant Program. These funds could be used for local law enforcement, for prevention, education, and treatment. Many counties use this funding for regional drug task forces especially in rural America. However, the administration zeroed out this program in its fiscal year 2006 budget request. NACo strongly supports restoring JAG funding during the appropriations process to deal with the problems of meth production and use.

In conclusion, I would like to again thank you, Mr. Chairman and Ranking Member Cummings, for the opportunity to appear today on behalf of NACo. We will be conducting future surveys on meth abuse and look forward to reporting our findings and working with you to resolve this issue legislatively.

Thank you, and I will be happy to answer any questions.

Mr. SOUDER. Thank you. And I can't tell you how much that survey helped us at a very critical time.

[The prepared statement of Ms. Brown follows:]

Statement of the Honorable Valerie Brown

Supervisor, Sonoma County, California

Before the

Government Reform Committee

Subcommittee on
Criminal Justice, Drug Policy and Human Resources

United States House of Representatives

On behalf of

National Association of Counties

"Fighting Meth in America's Heartland:
Assessing the Impact on Local Law Enforcement and
Child Welfare Agencies"

July 26, 2005

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

Thank you Mr. Chairman, Ranking Member Cummings and Members of the Subcommittee. My name is Valerie Brown and I am a County Supervisor from Sonoma County, California. I am a member of NACo's Health Steering Committee and a representative of NACo's Methamphetamine Action Group.

About the National Association of Counties

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

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

Methamphetamine

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

According to the most recent national data, 607,000 people were "current" users of meth—having used the drug sometime within the 30 days before being surveyed. Over the previous year, 1.3 million people had used meth.

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

Impacts of Methamphetamine Abuse on County Governments

County governments are on the front-line in dealing with the painful and costly consequences of methamphetamine abuse and production. The United States Drug Enforcement Agency estimates that 70-80 percent of methamphetamine is produced in "superlabs" in Mexico and California with the remaining 20-30 percent produced in "small toxic labs". These labs pose a significant risk to their community and represent the largest problem for local law enforcement. Investigating and busting small toxic labs, incarcerating and adjudicating meth users and cleaning up former meth labs are searing a hole in county budgets. County correction facilities are being overwhelmed by the increase in the number of meth related crimes and associated incarceration costs including mental health treatment, dental and other treatment costs. The need for and cost of county public defender services are also increasing at alarming rates because of the meth epidemic.

There are also many societal effects caused by meth abuse. In an alarming number of meth arrests, there is a child living in the home. These children many times suffer from neglect and physical and sexual abuse.

Meth labs pose a significant danger in the community because they contain highly flammable and explosive materials. Local first responders must be trained on how to identify and respond to meth labs in their communities. Additionally, for each pound of methamphetamine produced, five to seven pounds of toxic waste remain, which is often introduced into the environment via streams, septic systems and surface water run-off.

Meth abuse is a complex, difficult, growing problem that must be solved by cooperation among all levels of government and involvement by our citizenry. NACo is in the early stages of a national campaign to fight methamphetamine abuse. The primary objective of this initiative is to promote action by Congress and the Administration to control and reduce the production, distribution and abuse of methamphetamine, including assistance to counties in responding comprehensively to the problem locally. We look forward to working with this subcommittee and your colleagues on this undertaking.

As part of this initiative, NACo President and Umatilla County, Oregon Commissioner Bill Hansell has appointed a cross-cutting work group that has county representatives from all perspectives of the issue. The charge of our Methamphetamine Action Group is to further assess the impacts of meth abuse on county governments, educate county officials and the public on the dangers of the drug and identify best practices and local approaches that address education, prevention, enforcement, cleanup and treatment of meth challenges.

This afternoon, I would like to make three key points:

- **First, as NACo's two recent surveys confirmed, methamphetamine abuse is a national drug crisis that requires national leadership.**

- **Second, a comprehensive approach is needed to combat the methamphetamine epidemic. Necessary components would include law enforcement, treatment, prevention, education, public health, cleanup, research and precursor control.**

- **Third, existing programs, such as the Justice Assistance Grant program, foster care, and mental health and substance abuse programs are critical to the fight against methamphetamine and needed to combat this terrible drug.**

First, as NACo's two recent surveys confirmed, methamphetamine abuse is a national drug crisis that requires national leadership.
On July 5, 2005 NACo released two surveys on the methamphetamine crisis that has swept the nation. In the first survey, entitled, *The Criminal Effect of Meth on Communities*, is based on results from 500 county law enforcement agencies from 45 states. The counties that participated in the survey are representative of all counties nationally based on population and regional representation.

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

Additionally, 58 percent of county law enforcement agencies reported that meth is their largest drug problem. Meth outpaced cocaine at 19 percent, marijuana at 17 percent and heroin at 3 percent. In certain regions of the country, the percentages are even higher. In the Southwest, 76 percent of the counties said that meth is the biggest drug problem. In the Northwest, 75 percent said it was the top problem and by 67 percent of the counties in the Upper Midwest.

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

Stopping the small meth lab operations continues to be a problem. Concerning lab seizures, 62 percent said that meth lab seizures increased in their counties in the last three years.

Other crimes are increasing as a result of meth. Seventy percent of the responding officials say that robberies or burglaries have increased because of meth use, while 62 percent report increases in domestic violence. In addition, simple assaults at 53 percent and identity thefts 27 percent have also increased because of meth use. Sonoma County's Sheriff's department reports that 85 to 90 percent of our drug arrests are related to meth.

The increased presence of meth in many counties across the nation has increased the workload of 82 percent of the responding counties. These increased law enforcement activities from meth abuse are straining law enforcement budgets. Fifty-two percent of counties stated that they are

paying more overtime, while 13 percent have changed work assignments to accommodate the increase need for policing.

The Impact of Meth on Children

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

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

Forty percent of all the child welfare officials in the survey report increased out of home placements because of meth in the last year. During the past five years, 71 percent of the responding counties in my home state of California reported an increase in out of home placements because of meth and 70 percent of Colorado counties reported an increase. The results in the Midwest are frighteningly similar. More than 69 percent of counties in Minnesota reported a growth in out of home placements because of meth during the last year, as did 54 percent of the responding counties in North Dakota. In addition, 59 percent of county officials reported meth has increased the difficulty of re-uniting families.

Sonoma County is no exception. Just six years ago meth was the first or second drug of choice for approximately 21 percent of our clients and today it is involved in more than 41 percent of our cases. The effect on our child welfare agency is devastating. For example, in the last six months 20 percent of the infants we had to remove from their homes were due to meth use.

These drugs are often hidden in plain sight and are often accessible to very young children. In Sonoma, we have had several cases where children have ingested methamphetamine. In one case, a two-year old girl was left in the car unsupervised while her parents were visiting friends. The child found a bag of meth, bit into it and as a result ingested some of the residue. Subsequently, she developed significant behavioral reactions to the drug and had to be removed from the home.

Meth use is not limited to rural counties, nor is it limited to the West and Midwest. As a follow-up to the NACo report, one of our affiliate associations, the National Association of County Human Services Administrators, conducted an informal survey. Sacramento County, California, a large urban county, discovered that meth was involved in 70 percent of the family cases referred to court services due to substance abuse. Wilkes County, North Carolina reported that methamphetamine abuse has had the most significant negative impact of anything their child protective services workers have ever encountered.

Second, a comprehensive and intergovernmental approach is needed to combat the methamphetamine epidemic. Necessary components would include law enforcement, treatment, prevention, education, public health, cleanup, research and precursor control.

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NACo believes that a comprehensive and intergovernmental approach is required to fight the methamphetamine epidemic. A multi-faceted strategy that includes prevention, law enforcement, treatment, education, public health, cleanup, research and precursor control is required to fight this crisis.

Several collaborative efforts on the local level have endorsed this approach. For example, the San Diego County Methamphetamine Strike Force includes representatives from the federal, state and local levels of government. Federal officials include the Drug Enforcement Agency, the U.S. Attorney's office and Customs Services. State agencies on the Strike Force include the California Department of Corrections, the California Border Alliance Group, and the California Department of Justice. Local agencies represent a variety of perspectives including the courts, law enforcement, health and human services, environmental services and education.

Another example is in Pierce County, Washington, where county officials have developed a Drug Endangered Children's protocol for children found present at a meth lab. Additionally, when responding to a potential meth lab incident, Pierce County law enforcement officials are accompanied by a social worker to immediately assess the child's condition and recommend a course of action. Pierce County Sheriff Paul Pastor recently spoke at NACo's Western Interstate Region conference on the scourge of meth abuse in Pierce County. Pastor noted that, "merely using law enforcement to fight meth does not help." He continued, by saying, "it takes a multi-discipline approach. Prevention and treatment are also critical."

Similarly, Merced County, California, where 67 to 75 percent of its child welfare cases are meth related, the county child welfare agency has partnered with law enforcement and public health to form a Drug Endangered Children's team and has assigned a full time social worker to assist in drug lab raids. In response to the growing epidemic, the county is about to assign a second social worker to the teams.

Other critical components include prevention, research, treatment, education. Just last week at the NACo Annual Conference, county officials were heartened to learn that the White House Office of National Drug Control Policy will be airing awareness ads on methamphetamine to educate individuals on the dangers of the drug.

Additionally, one potential research breakthrough has already been achieved. Iowa State University researchers have developed an additive to anhydrous ammonia that can reduce the production value of meth, while still being a useful fertilizer.

Treatment has been proven effective when it is available and the individual is willing to accept it. The Matrix Model, consists of a 16-week intervention that includes intensive group and individual therapy to promote behavioral changes needed to remain off drugs.

Education and prevention efforts must be increased to inform children and youth about the dangers of methamphetamine abuse. Many former meth users indicate that they did not know of the ingredients and dangerous consequences of the drug before their first use.

Lastly, NACo believes that restricting the sale of precursors, such as pseudoephedrine, on the national level has great promise. Many states have seen dramatic reductions in meth lab seizures by restricting precursor sales. NACo also believes that eliminating the current blister pack exemption is a necessary step to impede meth production.

Third, existing programs, such as the Justice Assistance Grant program, foster care, and substance abuse treatment are critical to the fight against methamphetamine and needed to combat this terrible drug.

The FY2006 Bush administration budget request eliminated $804 million for the Justice Assistance Grant (JAG) program, including $170 million in discretionary funds. Currently, this funding is targeted to local law enforcement agencies for a variety of purposes including law enforcement, education, prevention and treatment. Many local governments are using this funding for multi-jurisdictional regional drug taskforces. County officials from across the nation have spoken out on the critical need for this funding. Without federal support for local law enforcement through the Justice Assistance Grant program, many of these multi-jurisdictional taskforces, particularly in rural America, would no longer exist. Therefore, NACo is calling on Congress to fully fund the Justice Assistance Grant program within the FY2006 Science, State, Justice and Commerce appropriations bill.

Over the last two years, the Administration's budget has included a proposal to allow states to turn their foster care program into from an open-ended entitlement a capped allocation with greater flexibility. While NACo supports greater flexibility in the foster care program, a proposal such as this is extremely dangerous. If the counties that are experiencing an increase in foster care caseloads because of methamphetamine use had been operating under a capped allocation, they would not have had the resources to respond quickly.

Conclusion

On behalf of NACo, I would like to thank Chairman Souder and Ranking Member Cummings for holding this hearing today. As our two surveys have confirmed, methamphetamine abuse is a scourge on our society that must be addressed in a comprehensive manner by all forms of government. NACo looks forward to working with Congress and the administration to craft and implement such legislation. Additionally, NACo is encouraged by the attention that methamphetamine abuse has received recently by the media and policymakers in Congress and the administration. Just last week, Attorney General Alberto Gonzales stated that, "in terms of damage to children and to our society, meth is now the most dangerous drug in America—a problem that has surpassed marijuana." Lastly, NACo will be conducting several additional surveys on other aspects of the methamphetamine epidemic, including treatment and public health. We would welcome the opportunity to come before this subcommittee and present our findings at the appropriate time. Again, we thank the Chairman and members of the subcommittee for the opportunity to submit testimony on the methamphetamine crisis facing this nation.

Mr. SOUDER. Ms. Baker.

STATEMENT OF FREIDA S. BAKER

Ms. BAKER. Good afternoon. Thank you so much for the opportunity to speak with you about the impact of crystal meth on children and families in Alabama. I have been a social worker for nearly 24 years, and I have worked with families who struggle with a lot of things, but this crystal meth epidemic is as dangerous and challenging as anything we face.

Without question, crystal meth poses a significant threat to vulnerable people in Alabama. The Department of Human Resources has several challenges with meth-related issues at the State level.

First, we must ensure the safety of children and provide effective services to individuals affected by the drug.

Second, we must prepare our workers through both education and direction.

And, third, we must craft policy and procedures so that consistent methods and safeguards are in place in each of the State's 67 counties.

There are important implications to the agencies that serve these children and their families in that, unlike other abuse or neglect scenarios, the home environment not only poses an immediate health threat to the children, but to any individual charged with providing services in that home as well.

Alabama's child welfare training curriculum has a newly expanded focus on substance abuse, but now, in addition to clinical training around the dynamics of substance-abusing families, workers must also be taught very specific meth-related investigative skills and cautions.

Select training for social work staff now often mirrors law enforcement in terms of function and role with meth. Workers are now, for example, routinely taught to look around outside the residence for suspicious items used in making or using meth, such as vents or piping sticking up from the ground, or booby traps, wires, surveillance cameras that appear to be there for no intended purpose. And even with Alabama's caseload standards, we find that an already-strained child welfare work force with young, inexperienced staff is further burdened with the complex dynamics of crystal meth. We find that workers leave the agency because of personal risks, the nature of these cases, and the challenges of working with these families.

Crystal meth has further complicated this multi-faceted issue in public child welfare. The number of children in the custody of Alabama's DHR has increased over the past 3 years. In 2001, there were approximately 5,400 children in foster care at year's end, and in 2004 that number had risen to 6,346 and continues to rise.

Reports of child abuse or neglect related to crystal meth have risen dramatically in Alabama, and these increases reflect our system's response to changing needs and issues.

Removal of children from their families is traumatic, and the added complications of meth use compound this trauma. If children are removed from active meth homes or labs, workers are instructed not to take any of the children's clothing or belongings from the home as they may be contaminated. Familiar clothing,

toys, blankets are often helpful for children in this distressing situation, yet meth prevents even those small gestures for them.

If there is obvious contamination of the clothes the child is wearing, clothing is to be discarded and left at the scene; then the child must shower as soon as possible. The child's personal things are left at the scene to minimize contamination of other areas or people.

In 2001 only 3.9 percent of the Alabama admissions to foster care were due to substance abuse. Last year in Alabama, nearly 20 percent of admissions into foster care were a result of family substance abuse. The treatment community in Alabama has recognized the addiction crystal meth imposes. John Schafer, the executive director of Pathfinder, a 12-step spiritually based in-house treatment program in Huntsville, reported that 45 percent of the entries there over the last year have been due to crystal meth. The faith community in Mobile has embraced the clientele at the Shoulder, a private Christian-based inpatient treatment facility for substance abuse. Employees at this facility, when faced with funding shortages 3 years ago, voted to take a decrease in pay in order to keep serving the community and report crystal meth as significant. Even in counties where numbers of children in care have remained stable, they cite crystal meth as being a much more frequent reason for removal than 18 to 24 months ago. Statewide efforts are underway to explore all the treatment scenarios and to standardize protocol. The problem calls for coordination with law enforcement agencies, safety instructions and, should the need arise, decontamination instructions.

Troy King, Alabama's attorney general, has designated a task force to address issues caused by crystal meth. DHR staff are members of the task force. The Alabama legislature recently passed the legislation regulating items that can be purchased to make crystal meth. The Governor's office has faith-based substance abuse initiatives, but meanwhile, the system's response to issues of imminent danger is to assess safety quickly and plan accordingly. Traditional resources and new creative strategies must be employed across all the human services agencies if we are to prevent and treat the abuse of crystal meth and all substances. America's children and families deserve our best efforts. Thank you for your time and attention. I am grateful for this opportunity.

[The prepared statement of Ms. Baker follows:]

BOB RILEY
Governor

State of Alabama
Department of Human Resources

Page B. Walley, Ph.D.
Commissioner

Prepared Remarks of

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

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

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

US House of Representatives

26 July, 2005

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

System Challenges

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

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

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

Children in Crisis

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

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

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

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

County Struggles

Calhoun

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

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

May 2005, 25 children entered care.

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

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

Cherokee

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

Cleburne

March 2002, 25 children in care.

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

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

Cullman

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

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

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

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

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

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

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

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

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

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

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

Statewide Information

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

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

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

Faith-Based Strategies

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

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

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

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

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

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

Mr. SOUDER. Chief Byers.

STATEMENT OF PHIL BYERS

Mr. BYERS. Mr. Chairman and distinguished members, I must first admit that being a political junkie and a C–SPAN junkie, I feel like I know each of you personally and have spent many, many hours with you at my home. It is indeed an honor to be here with you and to, first of all, thank you for what you are doing and a service that you provide to this Nation.

I am just one little chief deputy from—well, I am just one chief deputy from Rutherford County, NC—maybe not little. But I thank you for what you are doing, each and every one of you, for this Nation and for these hearings.

Rutherford County, NC, is a rural county. Again, we are in western North Carolina. We are comprised of 566 square miles and 63,000 residents. Rutherford County has historically relied upon a manufacturing-based economy, textile and furniture industries being the two largest employers. We have lost most of our textile jobs during the past 5 years, and the majority of the furniture industry jobs are also gone. Unemployment rates loom between 8 and 10 percent, far above the national average.

Rutherford County and her citizens will recover from the loss of manufacturing jobs with continued good leadership. The economic situation will improve if and only if we can curtail the present methamphetamine epidemic that we are facing. And yes, Congressmen and Congresswomen, it is an epidemic.

Methamphetamine addicts and cooks are driving some of Rutherford County's most costly social problems, including domestic violence, child abuse, mental illness, homelessness and the spread of hepatitis and AIDS. Rutherford County continues to struggle with social and economic setbacks caused directly by methamphetamine addicts and the manufacturers.

The North Carolina State Bureau of Investigation reported the following responses to meth labs in Rutherford County as follows: 2003, 34 lab responses; 2004, 43 lab responses; and as of June 30th of this year, 25 lab responses. Of those, five children were taken from meth labs in 2003; 2004, that rose to 24 children that we removed from meth labs. This year, as of June 30th, the number is up to 22. In 2004, in North Carolina alone, 124 children were removed from homes where methamphetamine labs were in operation; 24 of the children were residents of Rutherford County. This year, 2005, has already seen 22 children removed from homes where meth labs were operating in Rutherford County.

Many of the children removed from meth labs are abused and neglected and will suffer emotional consequences for the remainder of their lives. The number of children present in methamphetamine labs is expected to continue to increase at an even higher rate. As the number of children present at the laboratories increases, more will suffer the physical and psychological effects associated with exposure to dangerous chemicals, and the number of related abuse and neglect cases will increase.

Without a doubt, the most innocent victims of the meth epidemic are the children who are exposed. Chemicals contained and used in meth permeate through the rooms, thus leaving children exposed

to meth chemicals that can cause headaches, nausea, dizziness and even damage to the brain, liver, spleen, kidneys and immune system. In 2004, 2,700 children were found to be affected by methamphetamine labs seized by law enforcement officials nationwide. Children were present in 34 percent of the total labs seized in the United States.

The North Carolina General Assembly, Governor and Attorney General are working in conjunction with local and State law enforcement to combat the ills of methamphetamine production and addiction. In 2004, the criminal penalty for manufacturing methamphetamine was increased from a Class H felony to a Class C felony. Prior to December, the punishment for manufacturing meth in North Carolina was 6 months probation. This guarantees—the new class C felony guarantees prison time for anyone found guilty of manufacturing.

And again, the General Assembly is working to pass an additional methamphetamine lab prevention act. If approved, the act would limit the sale of Pseudoephedrine allowing the product to be sold without a prescription only by a registered pharmacist. The purchaser of the Pseudoephedrine would be required to present the pharmacist with a photo ID and must be 18 years of age. The name and address would be obtained, and identification could be used and entered into the record for consumers and for law enforcement use. Pseudoephedrine purchases would be limited to no more than 9 grams of any mixture of the product or any products containing a controlled substance within a 30-day period. This law, if passed, will benefit the law enforcement community, but that and that alone are not enough.

Restricting the sale of Pseudoephedrine products should occur in all 50 States. Rutherford County is contiguous to South Carolina, thus presenting only a short drive for Rutherford County citizens, Rutherford County cooks, if you will, to obtain Pseudoephedrine.

Rutherford County will continue to face economic setbacks as a result of methamphetamine addiction. The Rutherford County Sheriff's Office recently transferred two vacant positions to the narcotics division and obtained one new position through local funding. This expansion was due solely to demand being placed on our office by the increased meth labs and methamphetamine addiction. Additional funds will be necessary to pay overtime to our officers working the methamphetamine cases. The meth epidemic has caused a tremendous burden on local law enforcement budgets, and without State and Federal assistance, the moneys will not be available.

We have to this day been an area of local meth cooks making and selling the product. We have begun to seize Ice from Mexico and from super labs throughout the United States. Ice trafficking will continue to grow in Rutherford County, resulting in additional problems and abuses associated with meth addiction. We must place stronger and tougher restrictions on the Mexican border or Ice will continue to pour into the United States and into Rutherford County, and we will begin to experience an additional plague.

Social Services has also found themselves in budget shortfalls due to meth labs. The Rutherford County Social Services is currently in need of foster parents to accommodate the ever-increasing number of children being removed from homes where meth labs are

present. Social workers are constantly called to assist law enforcement when children are discovered to be living in meth labs. The department is also working to investigate and deal with child abuse and neglect cases as a result of meth addiction. Local mental health agencies are working to develop a successful treatment program for methamphetamine addicts. Current meth addicts have a recovery rate of less than 10 percent. Mental health resources will continue to deplete until a successful treatment program is developed to treat the long-term effects of meth addiction.

Mr. SOUDER. Mr. Byers, you are quite a bit over your five. Could you just go to your recommendations? And your whole statement will be included in the record.

Mr. BYERS. Absolutely. The recommendations that I would like to make are: No. 1, restrict the sale of Pseudoephedrine products nationally; tighten the Mexican border to help prevent meth trafficking from Mexico; address the Pseudoephedrine market in Canada and China; longer prison sentences for meth traffickers and meth producers and anyone who involves children in the trade or allows children to reside in a home used for meth production; continue to prosecute meth manufacturers at the Federal court system; longer sentences are beneficial to local law enforcement; continue funding interstate drug interdiction teams; and work with mental health care providers to develop a better recovery and treatment plan.

I thank you, Mr. Chairman.

[The prepared statement of Mr. Byers follows:]

To:	Members, Subcommittee on Criminal Justice, Drug Policy and Human Resources
From:	Chief Deputy C. Philip Byers, Rutherford County Sheriff's Office (North Carolina)
Date:	July 26, 2005
Re:	"Fighting Meth in America's Heartland: Assessing the Impact On Local Law Enforcement and Child Welfare Agencies"

Rutherford County North Carolina is a rural county in western North Carolina comprised of 566 square miles and 63,287 residents. Rutherford County has historically relied upon a manufacturing based economy with textile and furniture industries being two of the largest employers. We have lost most textile jobs during the past five years and recently lost the majority of furniture industry jobs. Unemployment rates for Rutherford County continue to loom between 8 and 10 percent, far above the national average. Rutherford County and her citizens will recover from the loss of manufacturing jobs and with continued leadership, the economic situation will improve and Rutherford County will return to its full economic potential. This will happen if and only if we can curtail the present methamphetamine epidemic that we are currently facing.

Methamphetamine addicts and "cooks" are driving some of Rutherford County's most costly social problems, including domestic violence, child abuse, mental illness, homelessness and the spread of hepatitis and AIDS. Rutherford County continues to struggle with the social and economic setbacks caused directly by methamphetamine addicts and its manufacturers. The North Carolina State Bureau reports the following responses to meth labs in Rutherford County as follows:

2003	34 Lab Responses
2004	43 Lab Responses
2005	25 Lab Responses (As of June 30, 2005)

2003	5 Children Affected as a result of Meth Labs
2004	24 Children Affected
2005	22 Children Affected (As of June 30, 2005)

In 2004, in North Carolina alone, 124 children were removed from homes where methamphetamine labs were in operation. Twenty-four of the children were residents of Rutherford County. This year (2005) has already seen 22 Rutherford County children removed from homes where meth labs were in operation. Many of the children removed from meth labs are abused and neglected and will suffer emotional consequences for the remainder of their lives. The number of children present at methamphetamine labs is expected to continue to increase at an even higher rate. As the number of children present at methamphetamine laboratories increases, more will suffer the physical and psychological effects associated with the exposure to dangerous chemicals, and the number of related abuse and neglect cases will increase. Without a

doubt, the most innocent victims of the meth epidemic are the children who are exposed to labs. Chemicals contamination from meth labs permeates every room of a home thus leaving children exposed to meth chemicals that can cause headaches, nausea, dizziness and even damages to the brain, liver, spleen, kidneys and the immune system. In 2004, over 2700 children were found in methamphetamine labs seized by law enforcement officials nationwide. Children were present in 34% of the total lab seizures in the United States.

The North Carolina General Assembly, Governor and Attorney General are working in conjunction with local and state law enforcement to combat the ills of methamphetamine production and addiction. In December 2004, the criminal penalty for manufacturing methamphetamine was increased from a Class H and I felony to a Class C felony. This guarantees prison time for anyone found guilty of manufacturing methamphetamine. The General Assembly is further working to pass the "Methamphetamine Lab Prevention Act." If approved, this act would limit the sell of pseudoephedrine allowing the product to be sold without a prescription only by a registered pharmacist. The purchaser of pseudoephedrine would be required to present the pharmacist with photo identification and would be required to be 18 years of age. The name and address obtained from the identification would be entered in the record of disposition to consumers. Pseudoephedrine purchases would be limited to no more than nine grams of any mixture of the product, or preparation containing the controlled substance within a 30-day period. This law, if passed, would benefit the law enforcement community but it alone is not enough. Restricting the sell of pseudoephedrine should be in all fifty states. Rutherford County is contiguous to South Carolina thus presenting only a short drive for Rutherford County meth cooks to obtain pseudoephedrine.

Rutherford County will continue to face economic setbacks as a result of methamphetamine addiction. The Rutherford County Sheriff's Office recently transferred two vacant positions to the narcotics division and obtained one new position through local funding. This expansion was due solely to the demand being placed on our office by increased meth labs and methamphetamine addiction. Additional funds will be necessary to pay over-time to officers working methamphetamine cases. The meth epidemic has caused a tremendous burden on the local law enforcement budget and without state and federal assistance; the monies will not be available. We have to this date been an area of local meth cooks making and selling the product. We have begun to seize Ice from Mexico and from "Super labs" throughout the United States. Ice trafficking will continue to grow in Rutherford County, resulting in additional problems and abuses associated with meth addiction. We must place tougher restrictions on the Mexican border or "Ice" will continue to pour into the United States and Rutherford County will begin to experience an additional plague.

Social Services have also found themselves in budget shortfalls due to meth labs. The Rutherford County Social Services is currently in need of foster parents to accommodate the ever increasing number of children being removed from homes where meth labs are present. Social workers are constantly called to assist law enforcement when children are discovered to be living in meth labs. The department is also working to investigate and deal with child abuse and neglect cases as a result of meth addiction.

Local Mental Health agencies are working to develop a successful treatment program for methamphetamine addicts. Current meth addicts have a recovery rate of less than 10 percent. Mental Health resources will continue to deplete until a successful treatment program is developed to treat the long term effects of meth addiction. Medicaid cost as well as health care cost will continue to rise with the physical and mental damage that is resulting from meth use. The future health care cost for meth users will be astronomical. Most if not all meth addicts are uninsured thus placing the cost back on Medicaid and the local governments. Rutherford County experienced a $700,000 increase in Medicaid in 2004-05. We can expect continued budget breaking results due to the epidemic that we are currently facing.

The future of meth epidemic in Rutherford County, North Carolina is uncertain. We are currently faced with local meth cooks producing their product at the risk of themselves, the community and the environment. For every pound of meth produced, eight to ten pounds of toxic waste will be produced. The environment will pay the price as most of our cooks dump the waste in wooded areas, thus causing potential water contamination. The children will continue to suffer as increased numbers are removed from homes involved in meth production. The long term physical and psychological damages to children will be extremely severe. State and local governments will be faced with ever increasing budget shortfalls as a result of meth abuse and meth addiction.

The facts are staggering and the differences from one county or state to another are minimal. All local Law Enforcement, Social Service, Mental Health, Health Care agencies, Environmental agencies and Schools will suffer severe consequences as a result of methamphetamine abuse and addiction. We must work together to fight this epidemic and hopefully reduce the negative influence that it currently has on our nation.

Recommendations:

1) Restrict the sell of pseudoephedrine products nationally
2) Tighten the Mexican border to help prevent meth trafficking from Mexico
3) Address the pseudoephedrine black market (Canada)
4) Longer prison sentences for meth traffickers and meth producers and anyone who involves children in the trade or allows children to reside in a home used for meth production
5) Funding for "Interstate Drug Interdiction Teams"
6) Continue to prosecute meth manufacturers in the Federal Court System (Longer sentences)
7) Work with mental health care providers to develop a better recovery and treatment plan

This information is based on my experience dealing with meth labs and the struggles that I have witnessed. I hope a small portion of this information will help to develop a better system of fighting what continues to burden our local governments in Western North Carolina. I thank you for your time and will be happy to address any questions or comments.

Mr. SOUDER. Thank you. Now you haven't just watched it; you have been on C–SPAN.

Ms. Deporto.

STATEMENT OF SYLVIA DEPORTO

Ms. DEPORTO. Thank you ladies and gentlemen.

I am Sylvia Deporto. I am the deputy director for children's services in Riverside County, CA. I began with the department in 1992 as a social worker, and methamphetamine was the No. 1 problem of substance abuse for child welfare at that time. I sit before you today on July 26, 2005, and I tell you that methamphetamine is the No. 1 substance abuse problem in Riverside, CA, for Child Welfare Services. It is an epidemic.

The Riverside County Drug Endangered Children Program is one of the most innovative multi-disciplinary projects to date. The Drug Endangered Children Program utilizes the Sheriff's Department, Child Protective Services, the District Attorney's Office, public health, nursing, medical personnel, courts, HazMat and environmental health to intervene on behalf of children who have been exposed to drug use, sales and manufacturing environments.

Drug endangered children are found living in about 45 percent of home-based methamphetamine labs covered within Riverside County. That figure causes great concern because one in every six illicit labs is discovered as the result of fire or explosion. The Children's Research Center Data on Safety Assessments for California Counties indicates that approximately 50 percent of children in Riverside County are removed from their parents by child welfare involve parental substance abuse.

In Riverside County, we have four law enforcement drug teams. Each of these teams has at least one social worker assigned to them full-time to assist with drug labs. Social workers must take the children removed from the drug labs directly to a hospital for evaluation and testing as part of the DEC program. The social worker may wait in an emergency room with the children for up to 6 hours. Many of these children have been neglected, demonstrating signs of malnourishment, lack of physical and dental hygiene, physical and/or sexual abuse and test positive for chemicals due to exposure.

Riverside County recently purchased four Community Resource Vehicles specifically for use by law enforcement and child welfare at drug labs. Due to the chemical exposure, the children need to be cleaned with water immediately, and in the past, this has occurred outside with a hose. The community resource vehicle will provide a place for the child to be cleaned in a shower and provided with clean clothes and fed while the social worker interviews them.

Children who are placed in the custody of Child Welfare Services require continued medical followup and evaluation. The social workers must ensure that these children are tested regularly for their chemical levels, and this information must be recorded in their health history. Many of these children have not attended school on a regular basis and must be provided with special education services to bring them up to grade level. Both foster caregivers and educators struggle with a multitude of behavioral problems and learning disabilities from these children due to prenatal

drug exposure to methamphetamine. Riverside County has initiated several drug courts, in superior, dependency, delinquency and family law, in an attempt to address the severity of our drug problem, its effect on the multiple agencies and, most importantly, its effect on our children.

I remember a case when I was still a field worker. The parents were methamphetamine abusers and were hiding from CPS with their children. They were located living in a very rural part of Riverside County in a small travel trailer. As we were taking the children, the parents were attempting to flee. The trailer was filthy, and the smell was overwhelming. At the office, the children stated to me that they used the bathroom outside just like the dogs do. They washed in the hose, and it was very, very cold. And they dumpster dived for their dinner every night. Children should not know a life like this.

I urge you to take notice of the severity of our Nation's problem with methamphetamine abuse. There are severe long-term consequences for our Nation and extreme costs. If you consider what we are currently spending on specialized law enforcement teams, hazardous materials teams, environmental clean up, child welfare and foster care, medical and educational costs to address the needs of these children, the dollars are overwhelming. We should put those dollars into prevention and treatment instead of in clean up.

I thank you today for the opportunity to share this information with you.

[The prepared statement of Ms. Deporto follows:]

Sylvia Deporto
Deputy Director
Children's Service Division
Riverside County, Riverside, CA

The Children's Research Center Data on Safety Assessments for California Counties indicates that approximately 50% of children in Riverside County removed from their parents by Child Welfare Services involve parental substance abuse. In Riverside County, we have four law enforcement drug teams. Each of these teams has at least one social worker assigned to them to assist with drug labs.

Social workers must take children removed from drug labs directly to a hospital for evaluation and testing. The social worker may wait up to six hours in an emergency room with the children. Many of these children have been neglected, demonstrating signs of malnourishment, lack of physical and dental hygiene, physical and/or sexual abuse and test positive for chemicals due to exposure.

Riverside County recently purchased four Community Resource Vehicles specifically for use by Law Enforcement and Child Welfare at drug labs. Due to chemical exposure, children need to be cleaned with water immediately and in the past, this has occurred outside with a hose. The Community Resource Vehicle will provide a place for the child to be cleaned in a shower and provided with clean clothes and food. The social worker will now have a safe place to conduct interviews with the children on site.

Children who are placed in the custody of Child Welfare Services require continued medical follow up and evaluation. Social Workers must ensure that these children are tested regularly for chemical levels and this information must be recorded in their health history.

Many of these children have not attended school on a regular basis and must be provided with special education services to bring them up to grade level. Both foster caregivers and educators struggle with a multitude of behavioral problems and learning disabilities due to pre-natal drug exposure to methamphetamine.

Riverside County has initiated several drug courts in an attempt to address the severity of our drug problem, its effect on multiple agencies and most importantly, its effect on our children.

Riverside County's Drug Endangered Children Program has provided us the opportunity to come together as professionals in an attempt to address this ever growing problem of methamphetamine use and abuse.

I remember a case when I was still a field social worker. The parents were methamphetamine abusers and were hiding from CPS with their children. They were located living in a rural part of Riverside County in a small travel trailer. As we were taking the children, the parents were attempting to flee. The trailer was filthy and the smell was overwhelming. At the office, the children stated to me that they used the bathroom outside "just like the dogs", washed in the hose and it was very cold, and they "dumpster dived" for their dinner.

Children should not know a life like this.

I urge you to take notice of the severity of our nation's problem with substance abuse, and in particular, methamphetamine abuse. There are severe long term consequences for our nation and extreme costs. If you consider what we are currently spending on specialized law enforcement teams, hazardous material teams, child welfare staff, foster care, medical and educational costs to address the needs of the children, the dollars are overwhelming.

I thank you for the opportunity to share this information with you today.

Mr. SOUDER. Thank you very much.
Ms. Dunn.

STATEMENT OF BETSY DUNN

Ms. DUNN. Chairman Souder and distinguished members of the subcommittee, I thank you for inviting me here to testify.

My name is Betsy Dunn. I am a Child Protective Services case manager at the Tennessee Department of Children's Services, and I am here to talk to you today about the worst form of child endangerment that I have ever seen. It happens when methamphetamine takes over a family's life and threatens to destroy everything, especially the children who have the misfortune of living beneath the same roof as their drug-addicted parents. I want to talk about some of the most pressing child welfare issues I face.

We need to offer collective support for these children. They need counseling that addresses their abandonment and attachment disorders. Our caseworkers and law enforcement officers need specialized training in dealing with these situations. Right now, we just don't have enough to offer all the help we need to try to get these children's lives back on track.

I live on the Cumberland Plateau, the highlands where middle and east Tennessee meet. It is beautiful country, and it has long been my home. Cookville is a growing city, but it still feels like a small town. And for the past 16 years, I have been a Child Protective Services case worker for the State of Tennessee trying to help some of Putnam County's neediest and most vulnerable children.

But the meth children are far different from anything I have ever seen before. The pressures on the State Child Welfare System are enormous in part because of the surge in meth-related custody cases in the past 5 years and, to a large degree, because of the way the addiction devastates the long-term well-being of the children who come from these homes. These are potentially life threatening environments to which these children are being exposed. The adults who are supposed to be these children's caretakers have become totally consumed by this drug and have turned their backs on these youngsters. It is not uncommon for us to see, say, a sibling group of three with the eldest child being 7 years of age, that 7-year-old becomes not only the primary caretaker for his or her siblings but the parents as well. These children's worlds have been totally destroyed. They endure physical and sexual abuse. These children are living in a world where they don't belong.

In addition to finding better ways to crack down on the specific ravages of methamphetamine-related child abuse, we have to recognize that these children require intensive and long-term help once we get them out of these dangerous environments. We have some good news, though. Now local, State and Federal law enforcement officers, prosecutors and child welfare experts routinely work together to combat this problem. Last year, Tennessee Governor Phil Bredesen assembled a methamphetamine task force that helped identify crucial legislation that Tennessee needed to fight the epidemic in our State. The Department of Children Services Commissioner Viola Miller asked me to serve on this task force. The meth problems in Tennessee, after all, are highly concentrated in my part of the State, so I see this firsthand.

Thanks to new restrictions on the display and sale of ephedrine and Pseudoephedrine, I am happy to say that it looks like meth lab busts are going down in my part of the State. But that is not to say that we still don't have a fearsome problem on our hands.

And the most heart-breaking part of it is the children who live in these homes with parents who are addicts. These aren't like other abuse and neglect cases that we see. When a child is taken out of a meth environment, this child loses everything that is familiar to them. They lose their clothes, their toys, everything because it is all considered contaminated, and that is what makes this so tragic. These children lose everything. They have lost their parents, and now they have to start over. In many cases, these children have raised themselves. There is a dull affect in their expression, and there is not a lot of emotion. There hasn't been any consistency in their lives because they live in environments that are deplorable. Some of these children don't even sleep in beds. They sleep on the floor. They have terrible hygiene. Their teeth are rotten, and no one is taking care of them.

When the Department of Children's Services caseworkers remove them from these conditions, they become our main responsibility as we try to address their physical, social and emotional difficulties. We struggle to find the services to address their needs. We do the best we can, but we just don't have enough. The majority of the children that we remove and place into custody are now because of methamphetamine-related issues. The foster homes have been totally flooded with these children. Therefore, if you remove a child for physical abuse or sexual abuse, you are going to have a hard time finding a placement because of all the other placements being taken due to methamphetamine.

In closing, I would like to tell you about a case that I worked approximately a year ago, and the child's name is Jeffrey. He was a 17-year-old mentally limited child. He was removed out of a methamphetamine lab. When interviewed by me, Jeffrey was able to tell me that his mother was doing bad stuff in the home, and it made him sick. He was able to describe step by step how to make methamphetamine. The most difficult part of this case was the fact that Jeffrey had just undergone a liver transplant. But I am happy to report that Jeffrey turned 18 years of age last year. In fact, our birthdays are on the same day, and we celebrated our birthdays together. We were able to save Jeffrey, but there are so many other Jeffrey's out there that we just don't know about. Thank you.

[The prepared statement of Ms. Dunn follows:]

Testimony of

Betsy Dunn
Child Protection Services Case Manager III
Upper Cumberland Region
Tennessee Department of Children's Services

Before the

U.S. House of Representatives
Government Reform Committee
Subcommittee on Criminal Justice, Drug Policy, and Human Resources

July 26, 2005

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

Chairman Souder and distinguished members of the Subcommittee, I thank you for inviting me here to testify.

My name is Betsy Dunn. I am a Child Protective Services Case Manager III at the Tennessee Department of Children's Services, and I am here to tell you about the worst form of child endangerment that I have ever seen. It's what happens when methamphetamine takes over a family's life and threatens to destroy everything – especially the children who have the misfortune of living beneath the same roof as their drug-addicted parents.

These are not merely cases of abused or neglected children, as bad as those kinds of case are already.

These are also about potentially life-threatening environment to which these children are being exposed. The adults who are supposed to be these children's caretakers have become totally consumed by this drug and have turned their backs on these youngsters. These children often live in fetid households, drenched in poisonous chemicals.

It is not uncommon for us to see, say, a sibling group of three, with the eldest being seven years of age. That seven-year-old becomes not only the primary caretaker of his or her siblings, but the parents' as well.

These children's worlds have been totally been destroyed. They breathe toxic fumes. They endure physical and sexual abuse. We see children that are actually participating in the manufacture of methamphetamine. I have spoken with plenty of children who are able to describe "that yucky smell that makes them sick." They tell me about how they can't breathe.

I've been there when a 17-year-old mentally challenged boy was led outside after a drug raid on his parents' house. He really didn't understand everything that was going on, but he had seen enough meth cooked know exactly what the process was. But what was especially tough to swallow was the fact that he was a liver-transplant patient who was somehow trying to recover while in the toxic environment of a homemade meth lab.

I've had children say to me, "Miss Betsy, my mommy's making that rock candy on the stove and it caught on fire and we had to leave the house."

I should tell you that I live on the Cumberland Plateau, the highlands where Middle Tennessee and East Tennessee meet. It is beautiful country, and it has long been my home. Cookeville is a growing city, but it still feels like a small town. And for the past 16 years, I have been a child protective services caseworker for the state of Tennessee, trying to help some of Putnam County's neediest and most vulnerable children.

The work is hard and often heart-rending. But when we get a report that a child may be in danger, you can bet that we hit the door.

The work can also be incredibly rewarding, especially when I'm driving down the road, and I see some of the kids I first helped years ago. They wave, and they yell "Miss Betsy! Miss Betsy!" Of course, I pull over and stop to chat. They're back with their parents, and it's so good to see that things have worked out for them. That's what my department always strives to achieve.

But my job took a drastic turn in 1999. I'll never forget that home visit. A co-worker and I went inside with the local law-enforcement officers. We were looking for a particular child, a child who wasn't there when we arrived. But we saw all of this strange paraphernalia lying around. Immediately, I developed a terrible headache. I couldn't stop coughing. It was like a bad case of bronchitis. There was a very strong odor in the home. It's like acetone, kind of a hospital-like smell. It's incredibly powerful, and once you smell it, you'll never forget it.

My co-worker started breaking out into a rash. I said, "What is this? What is going on?" It was my first meth case.

That night I still had the headache. I couldn't stop coughing. My co-worker developed a rash from the tips of her toes to the top of her head. When she went into the medical clinic the next day, she told them that she'd been in a meth lab the day before. The doctors shrugged. The workman's compensation wouldn't even cover it, because they just didn't know what it was.

Of course, we know all too well now what meth is. We know that meth labs are essentially hazmat sites. We know that methamphetamine can make users feel like Superman. We know that the drug is fiercely addictive. Tennessee has had to learn quickly about methamphetamine, as the effects of the drug began to ravage entire families and communities. Now local, state and federal law enforcement officers, prosecutors and child-welfare experts routinely work together to combat the problem, an epidemic of which I know the committee is well aware.

Last year, Tennessee Governor Phil Bredesen assembled a methamphetamine task force that helped identify crucial legislation that Tennessee needed to fight the epidemic. Thanks to new restrictions on the display and sale of ephedrine-based medications, I'm happy to say that it looks like meth-lab busts are going down in my part of the state. That's not to say we still don't have a fearsome problem on our hands. And the most heart-breaking part of it is the children who live in the homes with parents who are addicts.

These aren't like other abuse and neglect cases that we see.

When a child is taken out of a meth environment, this child loses everything that is familiar. They lose their clothes. Their toys. Everything. Because it is all contaminated. That is what makes this so tragic. These children loose *everything*. They've lost their parents. They have to start over.

Here is the drill that has become all too familiar in my part of the world: Imagine what it would be like for you to be sitting in your home watching TV one evening. There's a thud on the door. Suddenly police in SWAT gear come storming in. You're forced outside into the yard, where you meet someone like me. You're told to strip off all of your clothes and prepare for a decontamination shower. You're informed that you have to leave right now to go to the emergency room. People are hustling around in Tyvek hazardous material suits.

You say, "But I need to grab my purse." You're told you cannot take it because it's probably contaminated. You say, "But I need to grab my medications if we're leaving." You're told you can't have that. You can't have anything.

Now imagine what that must feel like if you're five years old.

In many cases, these children have raised themselves. There is a dull affect in their expressions; there's not a lot of emotion. There hasn't been any consistency in their lives. They live in environments that are so deplorable. Some of these kids don't sleep in beds; they're on the floor. They have terrible hygiene. Their teeth are rotten. No one is taking care of them.

When the children show up at school, teachers can smell the meth on their clothes. Babies born to meth-addicted mothers display some of the same symptoms of children born with fetal alcohol syndrome. You can't comfort them. They won't stop crying.

When we get these children out of these dangerous environments, after all while they seem to fine, but we can't really be sure: We just don't know the long-term effects of being around methamphetamine.

The majority of the children that we remove and place into custody are removed now because of methamphetamine issues. In my opinion, the foster homes have been totally flooded with these children. Therefore if you remove a child for physical abuse or sexual abuse, you're going to have a hard time finding a placement because of all of the other placements being taken due to methamphetamine.

Children Taken Into State Custody
Because of Meth Production
Upper Cumberland Region

2002:	123
2003:	179
2004:	114

Source: Betsy Dunn, Tenn. DCS

There has been an incredible outpouring of love for these children in Cookeville. We frequently have meetings with community groups to raise awareness. Civic clubs have helped these children get some of those toys they had to abandon back at their parents' meth labs.

But fund-raisers and quilting bees are not enough, of course.

In addition to finding better ways to crack down on the specific ravages of methamphetamine-related child abuse, we have to recognize that these children require intensive and long-term help once we get them out of these dangerous environments.

What do you say to a child when the parents don't show up for a custody hearing because they are too stoned? What do you say when the parents tell you, "I can give up my children, but I can't give up the drug"?

The kids' psyches can be stunted. They are often poorly adjusted socially. They need a lot of counseling to overcome the effects of their parents' meth addiction.

I do know that the legislation co-sponsored by Rep. Jim Cooper and Rep. Zach Wamp addresses some of those very issues – the need to offer collective support for these children. They need counseling. They need special training. Right now, we just don't enough resources to offer all the help we need to try to get these children's lives back on track.

The proposed federal legislation would help give us the desperately needed resources we need to take care of children who have been caught up in the effects of an especially brutal and pervasive addiction in my corner of Tennessee.

Thank you.

Mr. SOUDER. Thank you for your testimony. Thank you for your concern for the kids.

Chief Owens.

STATEMENT OF DONALD D. OWENS

Chief OWENS. Chairman Souder, Ranking Member Cummings, and distinguished members of the subcommittee, I thank you for inviting me here today to discuss the challenges and problems related to methamphetamine that we have encountered in Titusville, PA.

My name is Donald Owens, and I am the chief of police for the Titusville Police Department. I have been with the department for 22 years and have been chief for the past 5 years. In my years of service, dealing with methamphetamine in my community has been the greatest challenge that I have faced. Prior to 2001, few people in Titusville had ever heard of methamphetamine. Things were about to change however. That year, the first major meth ring in Titusville was busted. The individual thought to be responsible for bringing meth to the region was arrested. Meth purchased from him during the investigation was reported to be some of the purest that the lab had ever found. In part, this probably helped build Titusville's reputation as the meth capital of western Pennsylvania. It was reported that individuals from as far as 300 miles were coming to Titusville to get this new drug.

In 2001, when we first realized we had a problem, four labs were seized in the region. By 2004, the number of labs seized had grown to 69, which was over half of the total number of labs seized in Pennsylvania. Over a third of the 69 labs in the region were directly tied to Titusville. In April 2001, nearly 60 individuals from the Titusville area had been arrested on meth-related charges.

Looking at statistics on labs seized or arrests made does not tell you the whole story how methamphetamine affects a community. It doesn't tell you about the strain placed on the police. It doesn't tell you about the devastating effects of this drug to a community. The methamphetamine epidemic in our community presents many challenges to police. Some of the more serious concerns are manpower, money and increasing crime rates. Since 2001, the number of overtime hours put in by officers on the drug task force has more than tripled. When seeking grants to help our overtime costs, hiring officers or purchasing equipment, we find that, in the post-September 11th America, funding is geared toward larger cities or in dealing with threats from foreign terrorists. I would never say that foreign terrorists do not pose a serious threat to our country. But small town rural America is dealing with its own form of terrorism, the methamphetamine epidemic, and it is crying for help.

The methamphetamine epidemic has created other manpower issues as well. The Titusville Police Department has always had a very strong community policing policy which included conducting walk-and-talks through the neighborhoods in the downtown areas and presenting community education programs. Unfortunately, since 2003, our community policing efforts have been centered entirely around the methamphetamine issue. In 2003, we undertook a community education program to make residents aware of the seriousness of the meth problem. And we never anticipated the over-

whelming response our education efforts generated. The number of tips received has significantly increased. We could assign one officer to spend their entire 40-hour work week doing nothing but keeping up with intelligence reports and following up on leads.

The problem is that we don't have the manpower to focus solely on meth. We do have other crimes that we must investigate as well. In 2001, while the State's violent crime rate was going down, Titusville's violent crime rate doubled. Serious crimes such as burglaries and assaults have increased. We are finding that many of these more serious crimes are related to methamphetamine.

The Titusville Redevelopment Authority has worked hard to bring businesses into town but has expressed their concern that the methamphetamine problem may have businesses hesitate to move to Titusville. Without economic growth, the city may have to eventually cut back on services, including police. Taxpayers in the city are not going to be able to bear the burden as more houses are removed from the tax rolls because they have been condemned or torn down due to meth.

The conditions in meth houses are deplorable. We were once told by a narcotics agent who had worked in inner city Philadelphia and had entered some of the worst slums in some of the worst neighborhoods that he had never seen anything as bad as some of the living conditions in meth houses in the Titusville area.

We have been working with Congressman John Peterson to address the methamphetamine problem and develop strategies to deal with it as it moves across the State. Congressman Peterson has been instrumental in bringing agencies across our State together to address this problem, and I would like to take this time to thank Congressman Peterson for all of his help.

What are the solutions to this problem? I don't think there is going to be a quick fix to this problem any time in the near future. This drug has a stronghold on rural America. Additional financial resources on the State and Federal level are needed. I would certainly encourage Congress to continue funding programs such as the COPS program through which departments like Titusville may be able to hire additional officers to combat the methamphetamine problem in our region.

In order to truly understand what methamphetamine does to a community, just look how it has changed Titusville's reputation. Titusville has been known as the birthplace of the oil industry since the discovery of oil in 1859. The city has always been well respected throughout the region as a good place to live. Titusville is now better known as the meth capital of western Pennsylvania and has become the brunt of many jokes. In an Associated Press article talking about how meth is becoming a major problem in Hawaii, Titusville was mentioned as an example of meth's effects on rural America.

Rural America needs help. Rural America needs opportunities like this to express our concerns to you, our Representatives in Congress. Rural America needs someone to listen and to take action before the methamphetamine epidemic completely swallows us up.

I thank you for listening to me today, and I thank you again for the opportunity to speak here. And if you have any questions, I would be happy to answer them.

[The prepared statement of Chief Owens follows:]

Testimony of

Donald D. Owens
Chief of Police, City of Titusville, Pennsylvania

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

Hearing on

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

July 26, 2005

Chairman Souder, Ranking Member Cummings, and distinguished members of the subcommittee, I thank you for inviting me here today to discuss the challenges and problems related to methamphetamine that we have encountered in Titusville, Pennsylvania. My name is Donald Owens; I am the Chief of Police with the Titusville Police Department in northwest Pennsylvania. I have been with the department 22 years and have been Chief for the past five years. In my years of service in law enforcement, dealing with the methamphetamine epidemic in my community has been the greatest challenge I have faced.

Small Town Titusville

Titusville, Pennsylvania has that small town feel of comfort and security that many people seek today as they tire of the fast paced hustle and bustle of the big cities. People who grew up here then moved away to pursue education and career goals, often move back to raise their families. Titusville has always been a safe, close knit community.

The town's population of just over 6,100 hundred is deceptive. Titusville serves as the hub of activity for the tri-county area covered by the Titusville School District, which has a population of about 16,000. In addition, an influx of tourists in the summer and sportsman through the fall and winter greatly increases Titusville's transient population. The Oil Creek Valley offers many historic attractions related to the oil industry and was just named as a National Historic Region.

Founded in 1796, the town grew into a prosperous lumber community during the early 1800s. In 1859, an event occurred that changed Titusville, and in fact the world, forever. Colonel Edwin L. Drake drilled the world's first commercially successful oil well just outside of town and Titusville became the "Birthplace of the Oil Industry." In the early 1900s, the oil industry began to move out of the area into more lucrative fields in Texas and Titusville's economy declined. Fortunately, it didn't take long for a new industry to emerge to fill the gap.

Specialty steel brought renewed growth to the area. At one point, the main steel plant in town employed over 1,200 people. In 1992, the bottom fell out of the economy in the area. The steel plant was sold and the new owners closed it down. The mid 1990s were a time of severe economic hardship in the area. Many people were on unemployment or turned to welfare. This was also the time that methamphetamine, or meth, first made an appearance in Titusville.

Titusville's First Encounter with Meth

Prior to 2001, few people in Titusville had ever heard of methamphetamine. Things were about to change, however. That was the year that the first major meth ring in the Titusville area was busted. Eighteen individuals were arrested, including the individual thought to be responsible for bringing meth to the area. As the investigation was pieced together, it was learned that this individual used to travel to California to bring back drugs, mainly cocaine. His connection there introduced him to methamphetamine and taught him the cooking process. He brought this information back to Titusville in the mid 1990s. He controlled the meth trade in Titusville with an iron hand, guarding the cooking process and ensuring that only "quality product" was produced. Meth purchased from him during the investigation was sent to a lab to be processed. The lab reported it as "the purest meth they had ever seen." This in part, probably helped build

Titusville's reputation as the Meth Capital of Western PA. It was reported that individuals from as far away as 300 miles were coming to Titusville to get this new drug.

The Titusville Police Department was aware of this individual's drug use and sales, but his operation spread far beyond our jurisdiction. With the assistance of the Pennsylvania Attorney General's Office and the Pennsylvania State Police, a five year investigation finally resulted in arrests being made and the drug ring being broken apart. Or so we thought.

The arrests turned out to be the start of the problem, not the end. Whereas the "ring leader" had guarded the secrets of the cooking process in order to control the trade, after he was arrested he began to teach others the process while out on bail awaiting trial. He taught a lot of people. What started as an investigation of eighteen people, with easy to follow flow charts connecting each person, has grown into a web so tangled and far spread, flow charts now provide little help. It is estimated that one cook will teach ten others the process. Approximately 60% of those individuals will start their own "labs". And then each of them will teach ten others, and so forth. Well, this individual started that process here. Soon the number of cooks and users was growing exponentially.

When you hear about the meth production in the western or mid-western parts of the country, you hear about large cartels, usually Mexican cartels. As you know, these groups are strictly in the meth business for profit. They move into an area, cook large batches of meth, and then take their product and leave the waste behind. This is not the case in Titusville. We have never seen any evidence of cartels working in rural western Pennsylvania. The cooks and users in the Titusville area are all interlinked. Most can trace their meth use back to that first individual. They all know each other and usually work together to secure the items needed to cook. They cook to support their own habit, not to make money. The Titusville Police have yet to find a cook who isn't a user or a user who doesn't know how to cook meth. The problem in rural Pennsylvania started with one person and has spread out from there. Arrests have been made as far away as Mercer, PA, and Erie, PA, that have been linked back to Titusville's meth problem.

As I said, 2001 was the start. Below is a breakdown of the labs seized in the five county region covered by the PA Attorney General's Northwest Drug Task Force.

	2001	2002	2003	2004
Crawford County	2	3	7	41
Erie County	0	2	8	10
Venango County	0	4	11	11
Warren County	1	1	0	3
Forest County	1	1	3	4
Regional Totals	4	11	29	69
State Total	19	34	64	127

Crawford County has had the largest increase in lab activity over the span of four years, taking a big jump from 2003 to 2004. Of the 52 labs seized in Crawford and Venango County in 2004, 23 were directly related to the Titusville area and Titusville Police Drug Task Force investigations (this includes labs seized in Forest County and other locations outside the Titusville School District). So far in 2005, 15 labs have been seized in the Titusville area: four within the City limits and eleven in the surrounding communities.

Since April of 2001, nearly 60 individuals from the Titusville area have been arrested for the manufacture, possession, and/or distribution of methamphetamine. Of those 60, about 50 were arrests made directly by the Titusville Police Department. Others were arrests by the Attorney General's Office, Pennsylvania State Police, or other departments.

Meth Presents Many Challenges to the Community

Looking at the statistics on labs seized or arrests made does not tell the whole story of how methamphetamine affects a community. It doesn't tell you about the strain placed on police. It doesn't tell you about the devastating effects of this drug on the people, the economy, and the environment of a community.

Titusville Police have come a long way in their dealings with methamphetamine since that first investigation. Most of what we have learned, we learned by trial and error. We didn't understand the dangers of clandestine meth labs. Officers would serve search warrants and enter meth houses without realizing the potential health risks. At one of the first labs ever seized, several law enforcement personnel ended up being taken to the hospital after inhaling toxic chemicals. We were lucky no one was seriously hurt or killed. That incident made us realize that we needed to learn as much about this drug as we could. Officers attended classes taught by law enforcement officials from Missouri and other states that had been dealing with the problem for several years. We learned quickly. The more we learned, however, the more we became aware of how big a problem we had.

The methamphetamine epidemic in our community presents many challenges to the police department. I would like to highlight some of our more serious concerns.

- Manpower and Money.

  Titusville Police Department has 15 full-time officers, including myself. All of the officers in the department work on drug investigations within the City. The problem that the Titusville Police Department faces is that, as I stated, the City of Titusville serves as the center of activity for the communities that make up the Titusville Area School District, which covers approximately 200 square miles spread over three counties and has a population of roughly 16,000. While all fifteen officers can fight the meth problem within the City, until recently only five officers, working through the auspices of the Pennsylvania Attorney General's Drug Task Force, were able to work on investigations in the surrounding communities. The Titusville Police found that the harder they pushed the cooks and dealers in town, the more they just moved their labs into the outlying areas where it was easier to hide. Through a new

funding source, all of the officers in the department can be assigned overtime to work on drug investigations outside the city.

Since 2001, the number of overtime hours put in by officers on the drug task force has more than tripled. In 2001, 107.5 hours, about $2687.50 in costs at an average of $25/hour, were documented for meth investigations. In 2004, 287 hours, about $7175.00, were documented. So far in 2005, 151.5 hours, about $3787.50 in overtime costs, have been recorded. These figures may not seem like a lot for many departments, but to a department of 15, this is a lot of time and money. These figures do not include time spent for report writing or court appearances. Much of that time is done during the officers' regular work hours and limits the amount of time available for routine patrol work.

Moreover, the 2005 figures could potentially have been much higher at this point of the year. Like many other small departments, Titusville has to deal with officers being off for extended periods due to injury or illness. During the first four months of 2005, Titusville Police Department was down five officers, a full third of the department was off because of injury, illness, and in one case, active military duty. The officers that would normally spend their overtime hours working on the task force were now needed to put in overtime just to fill regular shifts and ensure that we had enough officers to cover the day to day emergency calls. You can only expect an officer to put in so many hours of overtime. At some point is becomes a safety issue.

These figures only include overtime submitted to the Attorney General for reimbursement. As I stated, we have spent over $3500 in overtime for drug investigations so far this year and could have spent more. We will probably spend well over $10,000 in overtime for drug investigations this year. This does not include overtime hours spent by the officers working on drug cases that fall strictly under our jurisdiction. The police department's annual overtime budget is $45,000. Normally about a third of that is dedicated to methamphetamine investigations. Without the assistance of the AG's Office, we would easily be spending over half of our overtime budget trying to combat this drug problem.

Titusville Police Department is fortunate to be able to draw on the resources of the Attorney General's Office Drug Task Force and the Pennsylvania State Police Clandestine Lab Response Team to assist in seizing meth labs. Without their help, the financial burden to the City would be overwhelming. Luckily we also have the support of a very giving community. In 2004, as part of our fight against drugs, the department decided to purchase a police canine. We sought donations from the community and were able to raise over $29,000 for the purchase of a drug detection canine and a new patrol car for the K-9 Unit. We were asked many times 'why don't you just get a grant for the dog' or 'why can't you get grants to help fight this meth problem'. There are no simple answers to those question except to say 'we've tried'. That is another hurdle with which Titusville, like many small departments, has to contend. Grants are hard to find and extremely competitive. What we are finding with many government grants is that in post 9/11 America, funding is geared towards large cities or in dealing with threats from foreign terrorists. I would never say that foreign terrorists do not pose a serious threat to our country, but we should not focus all our efforts in an outward direction and ignore the problems coming at us from within. Small town rural America is

crying for help with our own form of terrorism, clandestine methamphetamine labs and drug use, and we feel that no one is listening.

The methamphetamine epidemic has created other manpower issues. Titusville Police Department has always had a very strong community policing policy which included conducting "walk & talks" through neighborhoods and the downtown and presenting community education programs. Since 2003, our community policing efforts have centered almost entirely around methamphetamine. That year, we realized that we needed help from the entire community in fighting the meth problem. However, we never anticipated the overwhelming response our education efforts would generate. The number of tips received has significantly increased. Every day, several calls are received from individuals or businesses reporting suspicious activity that is meth related. Officers are stopped while on patrol and given information. They are stopped while off duty or called at home by individuals who know they are officers and want to relay information. We could assign one officer to spend their entire 40 hour work week doing nothing but keeping up with the intelligence reports and following up on leads. The problem is that we don't have the manpower to focus solely on meth, as we do have other crimes in town.

Increasing Crime Rates

In 2001, while the state's violent crime rate was going down, Titusville's violent crime rate doubled. That was also the year we had our first serious meth related violent crime in the City. A man high on methamphetamine went to a known dealer's house looking for more meth. He encountered several people outside the house. Following an altercation with another male, he pulled a gun and shot the man in the leg. He then waved the gun at the people in the yard, pointing it at a baby in a stroller at one point. The shooter fled the scene and went to an apartment building where he barricaded himself inside for several hours before the State Police SERT team fired tear gas into the house and he was forced to come out.

In the past two years, minor crimes such as retail theft and criminal mischief have actually decreased in the City. Serious crimes such as burglaries and assaults have increased. We are finding that many of these more serious crimes are related to methamphetamine use.

Judicial Response

This issue ties back to our manpower issues as well as being a major point of frustration for officers as they try to curtail the methamphetamine epidemic. Many of the 60 individuals arrested for methamphetamine in the Titusville area have in fact been arrested several times. At one house, labs have been seized on at least five separate occasions in the last year – two of the labs were seized within a week of each other. The officers spend numerous hours building a case against an individual for manufacturing meth only to have the charges pled down to a lesser count and the individual given what we feel is a rather light sentence, usually probation or a minimal amount of county jail time. Having pled guilty to or been found guilty of a meth related crime does not stop these individuals from continuing to cook or use meth. Suspects have no fear of being arrested. They have seen that when you are

arrested, nothing bad really happens to you. The police feel like their hands are tied and we are sometimes just going in circles. When we hear comments from the public, it is always that they feel the police aren't doing their job. We often receive calls or officers are stopped by citizens who ask why we can't do anything with these meth cooks. They see us arrest them and they see them walking the streets again within days. Here are just two example that illustrate our frustration:

- Titusville Police made a stop on an individual for a traffic violation. The day before, he had been found guilty of manufacturing methamphetamine and was out of jail on bond while awaiting sentencing. In his car was all the equipment to cook a batch of meth. The stop led to a search warrant being obtained for his residence and the discovery of a second lab.

- On another occasion, an individual was arrested for manufacturing meth. He pled guilty to a charge of possession with intent to deliver and the manufacturing charge was dropped. This is an individual who has been arrested by Titusville Police on numerous occasions. He received a sentence of 24 months probation. While on probation, he has been urine tested numerous times. Each time, he has tested positive for methamphetamine. While on probation, he was arrested and charged by Titusville police yet again for manufacturing methamphetamine after items consistent with a lab were found at his residence. Finally, he was placed in jail on a probation violation following this arrest.

There also appears to be a disparity between how methamphetamine cases are treated in the judicial system from one county to another. As I mentioned, Titusville is located where three counties come together. Our drug investigations have led to arrests in all three counties. Recently, a disparity between Crawford and Venango Counties has come to light.

In Crawford County, the officers are required to obtain much more information and evidence of lab activity before the District Attorney will authorize a search warrant, to the point that one lab was lost because the suspect became aware of the investigation and destroyed the lab prior to the officers being able to gather the needed information. The Venango County District Attorney will allow officers to get search warrants with much less information, and the search warrants have been upheld when contested in court. In Crawford County, individuals arrested for methamphetamine manufacturing have been known to receive very low bond conditions, sometimes being released on unsecured bond. In Venango County, we are seeing bonds set at $50,000 to $100,000 cash on a regular basis. As stated, individuals tend to receive probation or light sentences in Crawford County. We are seeing much stiffer penalties in Venango County. This inconsistency across the court system is extremely frustrating. Perhaps some of the problems within the judicial system come from the courts lacking an understanding of the seriousness of the problems we face in dealing with methamphetamine.

Effects of Meth on People, the Community, and the Environment

It is estimated that only 5% of those who are addicted to methamphetamine will ever be able to kick their habit and stay clean. That is 5% of those who seek help. An article just last week in the local paper reported that the number of people seeking help for meth addiction through the Crawford County Drug & Alcohol Executive Commission had nearly doubled in the past couple of years, up from 14 in 2002-03 to 27 in fiscal year 2004 -05. What the article doesn't report is how many of those 27 individuals are there under a court order. We have found that meth addicts, the serious meth addicts that we deal with on a regular basis, will not seek help unless they are court ordered to do so. Those who seem to be able to get away from the meth while in jail serving a couple of months sentence will go right back to it as soon as they are released. I'd like to share the personal side of methamphetamine use in Titusville, its effects on the people, the community and the environment. These accounts will hopefully give you a better understanding of the devastating and far-reaching dangers of methamphetamine.

- The People.

  That first individual who brought meth to Titusville needed to find places to cook that were secluded and where he would not draw the attention of a lot of neighbors. Through his dealings, he became acquainted with a woman who came from a very well-to-do family. She and her husband owned several hundred acres in the country. On the property was a "camp" that they did not use very often. This woman's husband was a former oil company executive and they were very prominent in the community. But, no one knows what goes on behind closed doors. Evidently there was something in this woman's life that made her go looking for some excitement. She had heard from some friends about meth and that it helped you lose weight. She thought this would be ideal for her perceived weight problems and she began taking meth. Soon she was letting the meth "ring leader" cook at her remote camp. She would often be present when he was there cooking. He would supply her with methamphetamine in exchange for using the camp. At first, the drug was "a wonder drug" for her. She dropped a few pounds and had all kinds of energy while on the high. She described it as being able to do house cleaning and other chores at a supersonic pace for many hours. She thought it was great. Then, the drug started to take over her life. She became paranoid. She started seeing green lights floating in the trees or coming under the door into the bathroom to get her. She thought people were living in the trees. She tried to hire a friend to shoot them for her. She wore rubber bands around her wrists to keep the aliens away. This all occurred in a short time period of just several months. Her life was falling apart. That was when the police knocked on her door. She was one of the eighteen people arrested during that first meth sweep in 2001. Because she had no past history and she cooperated fully with the police, she received a probation sentence. She quit meth on her own and started to work towards recovery. She started attending church again and leaned on her church family for support. When Titusville Police started doing their community programs, she offered to come and talk about how meth had affected her life. She seemed to be doing okay. But, there was always that feeling in her mind that she had let her family and friends down. She was ashamed of what she had done. She always thought that when she walked in to the grocery store or the beauty shop or a doctor's office that people were talking about her. In the fall of 2003, she apparently couldn't take the pressure of that feeling of

disappointment any longer. She committed suicide in the very camp where she had watched meth being cooked. She was 47.

Titusville Police were dispatched to a disturbance – a man standing outside his residence yelling and threatening people. When the officers arrived they indeed found this gentleman standing outside, yelling at people, breaking glass, and basically terrorizing his neighborhood. The man's actions were unpredictable. He would go from screaming at the police to stay away from him to begging them to help him. It was all two officers could do to finally wrestle him to the ground. He was handcuffed, behind his back, and placed in the backseat of a patrol car. While being transported to the police station, he at one point wedged himself onto the narrow ledge behind the seat against the back window. Then he proceeded to get down in the seat and literally rip the inside of the door apart with his teeth. The man had never been known to be violent prior to this incident. When he finally came down off his high, he stated that he did not know what happened. He remembered smoking a marijuana joint, but nothing after that. The investigation revealed that one of his "friends" had laced the joint with methamphetamine without the man's knowledge.

A man high on methamphetamine, upset that his wife had left him, went looking for her in Titusville. At one point he entered a residence, just walking in the back door without knocking. Then for some reason, he went to Titusville's water works plant to look for her. He broke into the plant and took one of the trucks for a joyride. When a city worker responded to the plant because the man set off the water pump alarms, the man tried to run him over with the truck, smashing through a gate and chasing him across a parking lot. Luckily the city worker was not seriously injured and no serious damage was done to the water plant, but the city worker is still suffering from emotional distress caused by the incident.

Children are often found living in houses where meth is cooked or used. The meth so consumes the parents that they don't care about taking care of their children. One young girl reported that her mother and another woman would lock her and her siblings out of the house while they did meth. Or, they would go into a shed in the backyard and lock themselves in it while they got high. The young girl said that she and her siblings were expected to go to relatives' or neighbors' houses.

On another occasion, Titusville Police were called to the Titusville Hospital because a woman had come in and just left three children at the main switchboard. When police finally located her, she stated that her neighbor had asked her to watch the kids while she ran some errands. "That was three days ago," she said. The mother had not returned and the woman thought that the hospital would know what to do with the kids. Once the mother was finally located, it was discovered that she had been out tweaking on meth with her boyfriend.

At another lab, two small children were taken out of the residence. During the course of their search, officers discovered a small table in the bathroom, about 2 feet high. On the table was a mirrored dish with a powdery substance on it. The substance turned out to be methamphetamine, well within the reach of the curious toddlers.

Below are some items that were recently taken out of meth labs. You can see how easily kids could think that it was okay to drink whatever was in the bottles. It looks like a bottle of Coke, maybe some water, or how about a Mello Yello. But in reality the bottles contain some very dangerous chemicals.

A.

B.

C.

A. Sodium hydroxide (Lye) mixed with water and iodine. This would melt the skin in your mouth and throat causing irreparable damage. To a child it looks like a bottle of Coke.

B & C. Both these bottles contain hydrochloric acid. This could blind you if it got in your eyes, chemically burn the inside of your mouth, or, if enough was swallowed, cause an electrolyte imbalance in your system and kill you. This could easily be mistaken for water or Mello Yello.

The incidents with children provides evidence that the methamphetamine problem is not strictly a law enforcement problem, but one that many social service agencies are facing as well. We deal with Children and Youth Services in our county on a regular basis while they follow up on reports of children being in meth houses. We are looking to work with them and the Department of Health to develop Drug Endangered Children protocals for our area that we hope will eventually be enacted statewide. These agencies, however, face the same manpower and money issues that the Titusville Police face. The methamphetamine epidemic is over-taxing many agencies.

- The Community.

The use of methamphetamine has brought an unwanted type of attention to Titusville, including national attention. As we stated, Titusville has long been known as the "Birthplace of the Oil Industry." When residents would travel outside the area and tell people where they were from, people would say "oh, Drake's Well". Now, when you mention that you are from Titusville, you are more likely greeted with "oh, the meth place". In an Associated Press article taking about how meth is becoming a major problem in Hawaii, Titusville was mentioned as an example of meth's effects on rural America.

Recently, a suspected methamphetamine lab was seized at a residence within the City. During the course of the investigation, video tapes were discovered showing three individuals having sexual relations with a dog. The tapes were taken to the District Attorney

and, on his recommendation, charges were filed. At the individual's arraignment, the local media picked up on the story and published an article on the front page. Within a day, national news had picked up on the article. References were made on the Steve & D.C. national radio show which is carried on a local station. Internet sites posted the story. The local paper, which can be read online, allows for posting messages about articles. Responses were posted from individuals as far away as Great Britain. The City became the brunt of numerous dog jokes. One citizen advised the police that she had received an email from a friend in Texas that began "woof woof woof." While one of the suspects was in the Crawford County Jail awaiting his hearing on the meth charges, the other inmates would walk by him and bark. But, he is an adult. The ones that were truly hurt by the actions of these three individuals were their school age children. They have been harassed mercilessly by other children, to the point that they do not want to go to school anymore. The actions of the three adults have been attributed by some to their involvement with meth.

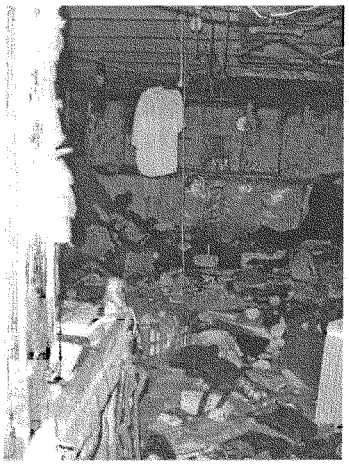
The real victims of meth are kids. Even kids whose parents aren't involved in drug use are victims of the meth problem in the community. Students from Titusville get teased and harassed by other schools. At athletic events in other towns, the chant of "methheads" is often directed at the teams and Titusville fans in attendance.

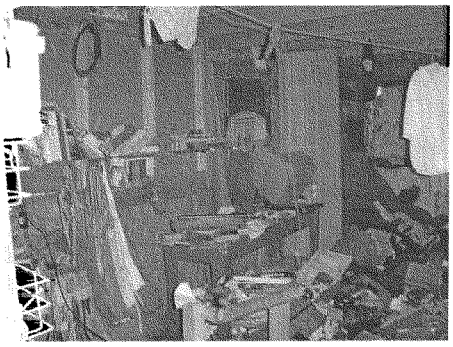
When the steel industry left the area, a group was formed to work to bring new business to Titusville. The former steel plant was redeveloped into the Titusville Opportunity Park which is able to house several small to mid-size industries and businesses. The Titusville Redevelopment Authority has worked hard to bring businesses to town. They have expressed their concern about the methamphetamine problem. Several businesses have indicated that they are hesitant to move into the Titusville area because of the problem. Without economic growth, the City may have to eventually cut back on services, including police services. Our small department is already barely staying even with the growing meth problem. A cut in the number of officers or in financial resources for our department would probably allow the meth epidemic to grow beyond our capacity to deal with it.

Taxpayers in the City are not going to be able to bear the burden as more houses are removed from the tax rolls because they have been condemned and torn down due to meth. Houses in otherwise well-kept neighborhoods become blights to the community as junk piles up in their yards and the houses fall apart from neglect due to methamphetamine. Below are two meth houses in the City that illustrate these conditions.

- The Environment.

  The conditions in meth houses are deplorable. We were once told by a narcotics agent who had worked in inner-city Philadelphia and entered some of the worst slums in some of the worst neighborhoods that he had never seen anything as bad as some of the living conditions at meth houses in the Titusville area. There is often filth and garbage all over the floors. Pots, tubing, burners and other items used for cooking meth are left laying all about. The residue and chemicals given off during the cooking process permeate the walls and furniture. Children can become "contaminated" because the chemicals will be absorbed into their skin. Below are several pictures taken of a local meth house.





These conditions are typical of what we find at meth houses. Several labs have been taken out of this residence.

A farm, located across the road from a residence where several labs had been seized, began having problems with its cattle herd. Several of the cows died while birthing their calves and other calves were stillborn. The water in the pond where the cattle drink tested. It proved to be very acidic, most likely contaminated by runoff from the lab sites or because the toxins had seeped into the water tables. Meth cooks don't care what happens to the toxic waste they are producing. They dump the waste on the ground or down their septic systems. They leave their discarded labs in the woods, in creeks, or just dumped along the roadway. This dump, which contained numerous meth related chemicals, was found on the property across the road from the farm.

In Conclusion

As I stated, dealing with the methamphetamine problem has been a great challenge. I have only been able to illustrate a few of our concerns and the challenges we face. The problem is big and getting bigger every day.

We are trying to reach out to other areas across Pennsylvania, to share our experiences and let them know what kind of storm is headed their way. We continue to work with the Pennsylvania Attorney General's Office, the Pennsylvania State Police, the Clandestine Lab Response Team, and other local law enforcement agencies to combat the meth problem. We have recently been able to discuss our needs for additional help and resources with the United States Attorney General's Office in Erie, PA. We have been working with Congressman John Peterson to address the methamphetamine problem and develop strategies to deal with it as it moves across the state. Congressman Peterson has been instrumental in bringing agencies across our state together to address this problem. I would like to to this time to thank Congressman Peterson for his help.

What are the solutions to this problem? I don't think there is going to be a quick fix to this problem any time in the near future. This drug has a strong hold on rural America. Some of the things that would help our fight in Pennsylvania would be additional financial resources on the state and federal level. I would encourage Congress to continue funding programs, such as the COPS program, through which department like Titusville Police may be able to hire additional officers to combat the methamphetamine problem in the region. Additionally, we would like to be able to use the resources of the Drug Enforcement Administration (DEA) on a regular basis. The problem we have is that the nearest office is in Pittsburgh, nearly two hours away, and it is not cost effective for agents to travel to our region to investigate "small labs". An office in Erie or Meadville, PA would benefit the entire northwest Pennsylvania region.

Rural America needs help. Rural America needs opportunities like this to express our concerns to you, our representatives in Congress. Rural America needs for someone to listen and to take action before the methamphetamine epidemic completely swallows us up.

Thank you again for giving me the opportunity to speak here today. If there are any questions, I would be pleased to answer them at this time.

Mr. SOUDER. Thank you.

And if I can take this opportunity before we hear our clean-up batter witness, Sheriff Shook, that I appreciate the specifics you have. If you all have additional information, as with each hearing, we have a hearing book associated with it, but as we try to pull together a meth report, these individual cases are helpful if you want to add others as well. And also if there is a way we could get some original copies of the pictures you have in this document if others have it as well, it will make any report we put together more effective.

Sheriff Shook.

STATEMENT OF MARK SHOOK

Mr. SHOOK. Chairman Souder, distinguished members of this committee, methamphetamine was something we heard about but believed was a far away problem, a California problem.

In the spring of 2002, a 312-square-mile semi-rural western North Carolina county with a population of 48,000 full-time residents was seriously impacted by the scourge of methamphetamine, and we were not prepared.

I am the sheriff of Watauga County, NC. I have been a law enforcement officer for nearly 20 years, and in this time, I have worked in many facets of local law enforcement. I have been a patrol officer, a detective and now sheriff. During my years of service, I have investigated murders, rapes, property crimes and even automobile crashes. Each of these significantly effect the people involved. The effects I've seen in our county from methamphetamine is not localized like these other crimes. Methamphetamine impacts in some way everyone around it.

Methamphetamine has penetrated our communities like the disease that it is. It is our families that are hardest hit. Methamphetamine addicts do not hold jobs. They do not contribute to our society. These individuals are users, plain and simple. They use our community's resources. They steal from their family members. They break into their neighbors' houses. They become physically aggressive to those around them, often to the people they love, even their children. Finally, they rob and kill because of perceived needs and paranoia.

So many times we have seen firsthand the hardest hit victims are the defenseless, the young children who are forced to live in conditions that are appalling by any standard. Time and again, we have raided active clandestine methamphetamine labs and found children living in those contaminated structures. We have seen baby bottles soaking in sinks full of chemical waste from methamphetamine production. I have taken teenagers from their parents' methamphetamine lab and found coffee filters with wet meth in their pockets, fresh from a methamphetamine cook. I spoke with a 6-year-old boy who lived with his mother and father in a meth lab. The 6-year old boy told me step by step the process his mom and dad used to manufacture meth, step by step. This child's parents had used him many times to assist them in cooking methamphetamine.

In January of this year, two small children were abducted at gunpoint from a foster home in Wautaga County by their biological

parents. The children were in protective custody because their parents were operating a meth lab in their house. These methamphetamine addicts found out where the children were housed, got a pistol, drove there and held the foster family at gunpoint while they took the children. Four days, an AMBER alert and one car chase later, we recovered the children, thankfully unharmed, in our neighboring State of Virginia. The parents were immediately arrested and searched. Again, they were carrying methamphetamine. The children are now back in foster care, and the parents are in jail awaiting trial on kidnapping, armed robbery and methamphetamine manufacturing charges.

In our small county we have had methamphetamine-related homicide, robberies and sexual offenses. In a county where murders are few and far between, most of the murders that have occurred in our county recently have had various ties to methamphetamine. Houses, mobile homes and apartments have burned due to the flammability and toxicity of the chemical mixtures people use while trying to manufacture methamphetamine. Many of these amateur meth cooks have been badly burned while trying to cook methamphetamine.

Clandestine meth labs represent the single greatest threat to the safety of emergency responders in our country. I have officers in my department that have been injured investigating meth labs. Six volunteer firefighters from one department in our county have been injured, one seriously and permanently, while working to extinguish meth-lab-related fires. These injuries are not from the fire itself nor a fall. These injuries are from the toxic fumes produced by the methamphetamine cooking process. We have been lucky in Wautaga County, NC. None of our responders have been killed. But around the country, firefighters, paramedics, law enforcement officers and many others in the public safety and public service industry are seriously injured or killed every year from the on-the-job exposure to these labs.

I was elected sheriff in 2002, and before my election, when I was detective at the sheriff's office in the year before I took office, I noticed a trend developing in cases I was investigating. I kept hearing the word meth. I was vaguely aware of methamphetamine from training and word of mouth, but I really didn't know much about it. What I did know was that meth was being identified with more and more criminal activity. A murder I worked earlier in the year turned out to be a meth lab dispute. Suspects in assault cases were citing methamphetamine as a contributing factor in their behavior. I came to understand that the community was suddenly awash in methamphetamine. I saw firsthand the damage resulting from people using this drug.

I knew we had to take action, and we did. We began an aggressive campaign against methamphetamine and people producing it. Some 80 meth labs later, officers in my department can point to tremendous success. We have been instrumental in passage of State laws that provide enhanced punishment for meth producers. We have made many arrests that lead to our serious meth producers receiving sentences ranging from State probation to more than 40 years in Federal prison. It is now difficult to find a clearcut meth lab in our county. There are still a few in operation, and we

are closing in on those. We do not find dump sites where lab-related materials are illegally dumped. But these have declined also.

We have worked hard to deter people from manufacturing meth and to make it more difficult to get the necessary materials. We have worked to educate our citizens, and we have developed relationships with our retailers. We established a three-county meth task force dedicated to the investigation and seizure of meth labs and arresting those responsible for their operation. We are continually fighting the methamphetamine epidemic.

Even with these efforts and the success that we have had, the use of methamphetamine is still prevalent in our area. We believe the majority of it is being brought in from western States and Mexico. We are fighting a battle working every day to rid our country of methamphetamine, and we are doing a good job. But we need help. We need laws passed controlling the sale of Pseudoephedrine, a necessary ingredient for meth production. States such as Oklahoma have passed legislation making it very difficult for meth producers to produce or steal large amounts of Pseudoephedrine.

Laws controlling the over-the-counter sale of Pseudoephedrine have had a significant impact and have contributed to a substantial drop in meth production in the States passing them. North Carolina is considering similar laws but has not adopted them as of yet. The passage of Federal legislation controlling sales of Pseudoephedrine will have the single biggest impact on illicit meth producers.

One of the primary reasons for our successes are the partnerships we have been able to develop. Gretchen Shappert and Karen Marston of the western district of North Carolina U.S. Attorneys Office; John Emerson and Walt Thrower from the DEA; Mark Triplett and David Schauble from the ATF; Van Shaw, Rick Hetzel and David Call of the North Carolina State Bureau of Investigation; and Charlie Byrd of the Wautaga County District Attorney's office, these are the names of some of the dozens of law enforcement officers and agents and prosecutors that have come to our small county and worked with us, educated us and stood beside us seizing labs and putting these criminals in prison.

Clandestine meth laboratories have moved east for some years now and have made it all the way across the country. They are a local problem, a State problem and now most of all a national problem. I anticipate that all of us in this room today will be discussing methamphetamine for some time to come. Thank you for your time and service to the citizens of the United States of America.

[The prepared statement of Mr. Shook follows:]

Watauga County Sheriff's Office

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Mark Shook, Sheriff

Methamphetamine was something we heard about but believed it was a far away problem; a California problem. In the spring of 2002 our 312 square mile semi-rural Western North Carolina County with a population of 48,000 full time residents was seriously impacted by the scourge of methamphetamine. We were not prepared.

I am the Sheriff of Watauga County North Carolina. I have been a professional law enforcement officer for nearly 20 years. In this time I have worked in many facets of local law enforcement. I have been a patrol officer, a detective and now Sheriff. During my years of service I have investigated murders, rapes, property crimes and even automobile crashes. Each of these significantly affect the people involved. The effect I've seen on our County from methamphetamine is not localized like these other crimes. Methamphetamine impacts in some way everyone around it.

Methamphetamine has penetrated our communities like the disease that it is.

It is our families that are hardest hit. Methamphetamine addicts do not hold jobs; they do not contribute to our society. **These individuals are users, plain and simple.** They use our community's resources; they steal from their family members. They break into their neighbors houses. They become physically aggressive to those around them, often to people they love; even their children. Finally, they rob and kill because of perceived needs and paranoia.

So many times we have seen first hand the hardest hit victims are the defenseless; the young children who are forced to live in conditions that are appalling by any standard. Time and again we've raided active clandestine methamphetamine laboratories and found children living in these contaminated structures. We've seen baby bottles soaking in a sink full of chemical waste from methamphetamine production. I have taken teenagers from their parents' methamphetamine lab and found coffee filters with wet methamphetamine in their pockets; fresh from a methamphetamine "cook." I spoke with a 6 year old boy who lived with his mother and father in a methamphetamine laboratory. This six-year-old told me step by step the process his mom and dad used to manufacture methamphetamine; **step by step.** This child's parents had used him many times to assist them in cooking methamphetamine.

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I anticipate that all of us in the room today will be discussing methamphetamine for some time to come.

Thank you for your time and service to the citizens of the United States of America.

Mr. SOUDER. Thank you.

I am going to yield to the committee vice chairman, Mr. McHenry, to start the questioning. And I'll be back in just a couple of minutes.

Mr. MCHENRY [presiding]. Thank you, Mr. Chairman.

At this time, I would like to recognize the ranking member, Mr. Cummings, for his round of questions.

Mr. CUMMINGS. Thank you very much.

First of all, let me say to all of you that we appreciate what you do every day. This problem is one that I think kind of snuck up on a lot of folks. And you know, as I listen to your testimony and listen to some of it, we have a TV in the back room there. I heard all of it. It strikes me that you are facing a problem that is much bigger than a lot of Americans can even imagine. And you need help.

When you were speaking, Ms. Dunn, I mean about the kids, and others of you have too, it just struck me that these are human beings. And so you get stuck in a situation where you are trying to take care of these children, and I guess you have but so many resources or alternatives, and yet and still I am sure you go home at night just, you probably can barely eat dinner trying to figure out, well, what is going to happen to these children. And in that vein, I just wanted to know, what is the most important factor that needs to be addressed when trying to reunite families that have been pulled apart as a result of meth use in the home? I mean, what is the difficult part of putting the family back together?

Ms. Dunn.

Ms. DUNN. Yes, sir. I think the most difficult part in reunifying these families, in our area—and I can only speak for Tennessee—we don't have any drug treatment. We have intensive outpatient. Sir, that is not going to work. That is something that we are in desperate need of, some type of treatment. I mean, a parent can go to intensive outpatient treatment for maybe 90 days, but that is not going to cut it. These parents are addicted to a drug that is stronger than anything I have ever seen. And I have been in this field for a long time, and I have seen a lot of drugs. But I have never seen a drug that could make a parent turn their back on their child, never.

Mr. CUMMINGS. Chief Byers, you were talking about C–SPAN. You know, you're on C–SPAN right now. Congratulations.

Mr. BYERS. Thank you.

Mr. CUMMINGS. The clean-up piece, that is a—we have heard a lot of testimony in other hearings about clean-up and how much time it takes and resources. How many people on your force?

Mr. BYERS. Sir, we have a total of 60 sworn officers.

Mr. CUMMINGS. So I guess when you have to clean up, there is a problem.

Mr. BYERS. There is a big problem. And the only clean-up crews that we have who are certified to go into the labs are in Georgia and Tennessee. So one problem we run into is, when we discover a lab, it might be 24 or 48 hours before a chemist can come in and check all the chemicals. A chemist has to come first from the State bureau and check the lab, and then the clean-up crew comes in, which is paid for by the Drug Enforcement Administration. But

still, it might be 2 days that we have an officer or even two officers assigned to that lab, and nothing can go on. So we are using manpower just to guard the lab, if you will. And the danger continues as the water, the environment continues to be plagued with that while we were waiting on a clean-up crew, and that is just—we are thankful that they are there. And we are thankful the Federal Government is paying for it, because we certainly couldn't afford the clean up. We couldn't afford it whatsoever. But it is very time-consuming and maybe 2 days before the lab can be cleaned up, tying up our officers as well as Federal and State officers.

Mr. CUMMINGS. How does that affect your other efforts with regard to law enforcement? I mean, you know, one of the things that—I practiced law for many years, and I think that when people see, the criminal folk, when they see that there is an opportunity to do their criminal act, then they take advantage of it. And I was just wondering, you know, does that send a message, now? They know you've got to deal with that kind of issue. They know you've got a limited force. I mean, have you seen problems in other areas, that is, criminal activity?

Mr. BUYER. Absolutely, Congressman. In 2004, when our SBI and our department responded to 43 labs in Rutherford County, crime was up double digits in larcenies, property crimes as a whole, simple assaults and domestic violence, and all those are directly related to meth and meth manufacturing. So, yes, we have seen a big swing.

Mr. CUMMINGS. How about you, Chief Owens?

Chief OWENS. They would pretty much follow along the same lines. Any time we get involved with the methamphetamine, you see additional crimes being committed because of the drug itself. And it is, the deplorable conditions that these people are living in is conducive to additional problems for children and youth, too.

Mr. CUMMINGS. What would you all—my time has run out, but, what would you all want to see us do as a Federal Government to help you? I mean, if you could just answer that in just a very, very few words. I mean, whoever, some of you may not even want to answer that. But I am just curious.

Ms. YOUNG. Prevention. Mass prevention efforts. The public needs to be educated about this issue. We need to educate pregnant women about use during pregnancy for methamphetamine as well as all of the other substances that affect their children. We need to make sure that obstetricians know about this issue and that they are screening effectively and providing intervention so that we can prevent that damage. The public doesn't, as many Members have already said today, may not be really recognizing what the long-term consequences are, and mass education about this issue really needs to happen with a doubling of our prevention efforts.

Ms. BROWN. NACo actually supports four of the bills that are circulating through the congressional levels now; some that deal with clean up, some that deal with Pseudoephedrine restriction. And we want you to know that we really appreciate what you have been doing. I think that the direction of moving in a comprehensive way is the only way that I think we can address this problem and maybe get to a place where we feel like we have achieved a goal at the end.

And I think everyone who has testified has said that all levels have to be involved; not levels of government but all departments within counties that are dealing with it, all departments within cities, that the Social Service component needs to be side by side with law enforcement, and that there needs to be this understanding and that treatment is a valuable component of that. So we would be supportive and we have a president this year that is from Umatilla County, OR, who has recognized the importance of methamphetamine and raising that awareness and has made it his initiative. So you will hear much from us in NACo about the need to look at this from all different sectors with a comprehensive approach I think is the best.

Ms. BAKER. If I may, I would agree with the education piece and also sort of the spirit of, all hands on deck. I mean, the whole piece around collaboration with law enforcement and others. It is real easy to sort of be tempted into thinking that foster care is a premium solution, and you know, children need to be safe and have permanency and well being in their lives. And without treatment, without the education and prevention piece and treatment, we may be creating another generation of youngsters who would be well cared for by the State, I would hope, but who deserve permanency and connections with their families.

Mr. CUMMINGS. Mr. Chairman, if I may I just have one question, one more question that I think may be helpful to some police chiefs who are watching this right now. Just recently, in Maryland, we had a situation—it has not been a big problem in Maryland. But we recently, I mean within the last 2 weeks, had a situation in a rural section where a lab was discovered. And I am just wondering, when you were talking, Chief Owens and perhaps you can help us, Sheriff Shook and others, when, if you had—looking back, when you first saw it, is there, are there some things that you wish you had done and maybe just kind of—you know, I am not saying you underestimated, I don't know what happened—but I mean, in other words, that you wish you had done at that moment, as soon as you, the moment you saw something happening and that, if you were giving advice to other chiefs, what would you say? You understand the question.

Chief OWENS. I do. I think one of the things we did is we did a community presentation. We went around the area with an educational program, a Power Point program, went to all the outlying areas. And we are very rural in nature. Went to the fire departments and talked with the EMS and fire departments and groups, and we also took it into our schools. We talked to them at the school level. And I think when we started showing them some of the pictures that some of the—that came across big with them. I mean, sometimes, like they say, a picture, you know, paints 1,000 words. But I am going to tell you, that is pretty devastating when you start looking at some of those pictures that were up here on the board today, and I think that gets people's attention, so I do believe education is part of it.

And I think you need to act as quickly as you possibly can when you realize that you have a problem, and fortunately, we have done that. But unfortunately, this epidemic is so sweeping, and it takes no time at all before it is overwhelming. It happens that quick. And

it is real trouble for people trying to deal with budgets and trying to deal with the problem as well.

Mr. SHOOK. When we started finding our problem, the first thing we did was get the education for our law enforcement, our emergency services, our health departments, our Social Services. We also made a pact with our Chamber of Commerce and our retail establishments and educating them, the hotel owners associations, the renters, because it is a community problem. It is not a law enforcement problem. It is a community problem, and everyone in that community has to deal with it. That is where I am proud of our county, because we have banded together, and we have made a difference in our county. But I think education working hand in hand and limiting the availability of Pseudoephedrine products will take care of the meth problem because, without Pseudoephedrine, there is no meth.

Mr. CUMMINGS. OK. Thank you all.

Mr. MCHENRY. Thank you, Mr. Cummings.

And certainly, this is a bipartisan issue. I mean, the concern that we have as a committee on this epidemic of methamphetamine across our Nation, it is very serious, and this Congress takes our job seriously in making sure that we have the laws and everything, the resources available to combat this problem. The interesting thing about this panel is that none of you are from Washington, DC, but surprisingly, you make sense. Wait a second. I guess those two things actually go together. No, it is wonderful that we actually have these are on the front lines here today to give us recommendations. What is so surprising about the eight-member panel that we have here is that you have twice as many recommendations, no actually probably more like 100 percent more recommendations than the first panel did. And I think it is wonderful that you all are here to convey that.

My questions for my local law enforcement leader, Mr. Byers, you spoke about Rutherford County. And the meth problem is touching Rutherford County like it is many rural counties across America. We are not exempt or immune to it. You spoke about the economic issues in your opening statement, that you and local law enforcement have to deal with. Can you go more into detail about the economic impact?

Mr. BYERS. Yes, Mr. Chairman.

The money is being spent in Rutherford County. Our Medicaid budget, the local budget portion for Medicaid in Rutherford County last year increased $700,000. That doesn't sound like a lot in Washington dollars, but I'll assure you, in Rutherford County dollars, that is a lot of money. And most of that money went to those who are afflicted with methamphetamine and methamphetamine addiction. We are seeing a tremendous amount of money spent in our local detention facility. We have a 210-person detention facility, and right now, our budget is at $1.7 million for that facility. And a lot of that money is going to health care. The biggest spending that we are going to see with methamphetamine and of course the worst thing is the loss of life of course. That is the No. 1. But the big spending is going to come in the future with health care costs for liver and kidney failure, for diabetes, for heart attacks. And we are seeing those things in our detention facility now. So the one

thing that is rising constantly in law enforcement in Rutherford County is the medical expenses we have at our 210-man facility, our detention facility. That is going to continue to grow. We have inmates who are suffering from everything from diabetes as a result of meth abuse to heart failure to kidney and liver failure to HIV. And that is going to continue not only in Rutherford County but with the Department of Corrections in the Federal prison system. We might as well get ready to spend a fortune of money for health care.

Mr. MCHENRY. Well, this is certainly an issue. And in terms of local law enforcement, the resources you need, are you getting those, the funding you need to meet the demand that this is placing on your people?

Mr. BYERS. Congressman Cummings asked earlier about what would we do, the one thing. And I think avoiding the head-in-the-sand mentality, if you will. You know, it was in California. It started east. Oklahoma. Then, you know, people in North Carolina said, it's never going to affect North Carolina. It will never make it to North Carolina. Well, it made it to North Carolina. We in the west were fighting it. We were fighting it hard. And we had counties in eastern North Carolina who were saying, it's not a problem. We don't have methamphetamine. Charlotte-Mecklenburg, had their first meth lab last week, their first for this year. So for Charlotte-Mecklenburg and the chief there, it may not be a tremendous problem, but I promise you it will be. And resources in law enforcement, we have had to move people from other positions to narcotics. Our narcotics division has doubled in size based on methamphetamines and will continue to grow. And we are asking for some additional funding.

But in a county with 9 percent unemployment, it's hard to ask that county commissioner for a lot of money. He gives you a long look when you ask for tax dollars when you've got 9 percent unemployment. So it is more than just local issues, for local law enforcement dollars, not a lot of money being seized.

When we were in the cocaine business—and not that we are not in it still, we made a lot of arrests for cocaine. I know you were mentioning in Baltimore. But we would seize homes and cars because it was a seller's market. We would get a little money come back into law enforcement to help offset some of the expenses. With meth addiction, they have nothing. They're broke. They don't have a dime. They're stealing lawnmowers and chainsaws to buy the ingredients to make the meth. So we are not seizing any property. We are not seizing homes, cars. All we are doing is spending money. So there is nothing coming back to the coffers, and we are standing there before our commissioners and before our State legislators and before our Congressmen with our hands out asking for help. So it is affecting us tremendously.

Mr. MCHENRY. What is the single best thing we can do in Congress to help your fight? If you could touch on that, then we can go to Chief Owens and Sheriff Shook.

Mr. BYERS. That's a tough one for me because I have really got a couple or three. But the first thing is to ban or restrict—ban is not a good word—restrict the sale of Pseudoephedrine products. And it can't be just State by State, because, again, the people, the

cooks in Rutherford County are going to drive 15 minutes and steal or buy all they want in South Carolina. So it needs to be a national restriction of the sale of Pseudoephedrine products. And that would be No. 1.

And then I would have to say, looking at the borders of Canada and Mexico, and Ice is beginning. We are going to change in Rutherford County from a manufacturing base where we have our cooks that go out and buy the ingredients, make the meth. Now we have a lot of addicts running around Rutherford County; 6 percent recovery rate, so that is going to continue to grow. And now that the demand is there, it's supply side economics. The demand is there. The Ice from Mexico will hit the streets wide open. Congressman, you know what that's like in Baltimore as far as dealing with other drugs. So we need to really look hard at what's coming in from Mexico and the Pseudoephedrine coming from Canada.

Mr. MCHENRY. Thank you.

Chief Owens.

Chief OWENS. I certainly agree with Chief Deputy Byers. One of our problems is that our meth is not being imported. It is being made locally. And that is one of our biggest problems. What we need is manpower and money and to address the problem from a law enforcement perspective. And that is where our issues are.

Mr. MCHENRY. Sheriff Shook.

Mr. SHOOK. I think limiting the sale of Pseudoephedrine. We also need manpower. Our State Bureau of Investigation is understaffed. Their lab is unstaffed, their chemists. We need more chemists because most of the SBI lab chemists that are doing the DNA testing and other testing in the lab settings are having to leave those laboratories and come out into the field to process meth labs. So that is putting backlogs in murder cases and rape cases and other law enforcement problems. So we need manpower, and we need some restrictions on the main ingredient that causes this problem.

Mr. MCHENRY. Thank you all so much for your testimony. I saw a number of head noddings when we came to Pseudoephedrine and certainly the universal issue here in the base of all that we are talking about. So thank you so much for your testimony.

Ms. Watson.

Ms. WATSON. Thank you, Mr. Chairman.

And I just want to say to the panel that we are very, very appreciative that you came today to not open my eyes but open our eyes as to the gravity of this problem. And it was said from the Chair that there is no one here from D.C.; well, thank goodness you came in from across the country just to show the expanse of this problem.

I want to address my comments to Valerie Brown. And thank you so much. I am personally involved in a case as we speak. And I was listening to your recommendations as to what you need to fight this problem. You are not helped by the fact that I think America is a drug culture. All you have to do is put on the TV, turn on the radio or read the paper, and they are selling you something to put you to sleep, to wake you up, to quell the pain, etc. So our children become used to taking drugs. There is a case of a young woman who had been on meth probably 10 years, and it affected her heart. It affected her kidneys. It affects heart, kidneys. Let's

see. And she's diabetic. She flatlined three different times. She went through the county hospital services in Sacramento. Her mother had been in as a patient for neurosurgery. She had a baby daughter, 18 months old. This was a household heavily impacted by that one child who was 19 at the time that she fell ill.

Now here is the question I have to ask: She went through four different hospitals. When she was doing better, they put her in a taxi and sent her home. Her mother couldn't take care of her, because she was recuperating from her surgery and she had not filed all the papers with the county, the mother for the daughter, 19.

I got involved and had a meeting at the hospital and said, you've got to keep this patient here, she is critically ill.

Well, they finally put her on a list for a transplant. Her heart has a hole in it from this continuous long-term use of meth. The problem is that she could not go into foster care because she was over 18 years old. The hospital did not want her to stay there because any time she goes out, she used meth again.

And the social worker said there is no placement. We can get a senior placed or an infant placed, but there was no place for a person who was 18 and beyond.

If we look at this whole problem from beginning to end, there are holes in it, because we don't know enough or we haven't really done the national studies, I think, as to what should be part of the treatment.

Ms. Brown, what would you suggest we do with that young woman who is 20 now, and needs help, needs aid? She is at home with her mother, who is incapacitated. She has a daughter. She finally qualified for in-home support services, but she needs to be, at this current time, institutionalized because, what I can tell, is that the continued use over a long period of time of meth has affected her thought processes as well.

Ms. BROWN. And they, Congresswoman, are under assault as well. Hospitals are under assault. So it seems like it doesn't matter where you go in the health care system, it's not providing the kind of care and treatment that we are looking for. One of the most encouraging things I think that we have here is actually from Paul Pastor up in Tacoma, WA in Pierce County. And he said they had brought in a gentleman who was talking about their treatment program, and he said, you know, people kind of believe that methamphetamine is such a bad thing that there is no treatment that can ever cure or help or fix it.

We have been doing an active study. We have active data. That data does tell that story. It says we can work with people in the community. There is great encouragement from the treatment of it, from the health care, all the people here.

We are having a hard time accessing a system with less and less dollars, not only that we have available to us from our county revenues, but from our Federal revenues. Medicaid and foster care is under assault. Really, how can you expect to continue to provide for all of these people that we are currently seeing coming into the system needing care when we don't have the resources to do it?

We are really trying, greatly, just to take care of those that are there now, that they have become the urgent care instead of just the urgent. So I absolutely agree with you, the system needs to

look at the treatment and the health care end as well as the law enforcement as well as the cleanup. It has to be total.

And just something I wanted to add that has not been mentioned at all today. We look at cities and we look at counties, and we look at how they're dealing with the problem. But we have States in the Northwest that they are predominately BLM land. And there is no one watching that store. And we find that the mobile society of meth producers in their vans will go anywhere that we are not.

So they will go to the back lands, into Nevada, into Idaho, into Montana and into Wyoming. And it gets filtered right down to Rutherford County, NC, only now it's in a form that is salable.

There needs to be a national approach, and that is one of the reasons we suggest we need the top priorities. We need the national leadership that you can provide.

Ms. WATSON. Let me just thank you so very much for those comments and go back to Dr. Young. As a Director of the National Center on Substance Abuse and Child Welfare, my question to you is do we have a plan? Are we thinking through how we can make our treatment programs, prevention programs national, comprehensive? And as I said, there was a hole in the treatment. After the hospital kicks this child out, there was nowhere that would take her. So they sent her home in a taxicab where she couldn't be cared for there.

So as I said, there are holes along the way. And I agree with Ms. Brown. It has to be comprehensive. It has to be linked across the States. And people should not be able to go from State to State and find that they can get away with it in Utah and not in California, but in Utah they can.

What is your thinking on that? And are we discussing it in a commission type structure?

Ms. YOUNG. I don't know about in terms of a commission type structure. I do know that our organization has worked with about eight States at present in the 2½ years that we have been operating to create comprehensive State plans to address the substance abuse issue in child welfare.

Those States have looked comprehensively across treatment and intervention for children and the child welfare interventions to put plans in place to do just what you're talking about. I think there are communities that have been serious about this issue for quite some time. I cite Sacramento County in my written testimony, and you see the recovery rates that they're achieving regardless of the type of substance that is being used. And you see the faster reunifications that are happening by doing some very specific things, ensuring that comprehensive services are available very early in the case, even before the court has taken jurisdiction in a case in which children have been removed. They are offering services from day one. And they have defense counsel on board to say to parents, your best chance, your best hope is engagement in a recovery process in order to regain the custody of your children. They have been at this for some time. They're seeing positive results. There are places around the country that have put those kinds of plans in place.

Is it widespread enough? No. Probably not. Are they ready to address the methamphetamine issue? I think that we need to be a bit

ahead of the game. You certainly recognized the cocaine and the crack epidemic 15 years ago. I think this is our opportunity to ensure that comprehensive family based treatment and prevention efforts are in place for these families.

Ms. WATSON. Thank you so very much. I just want to say to the Chair, I know I am out of time. But maybe we can ask some of these good people to come together and give us the framework for maybe a piece of legislation, because this is a serious problem and it is killing our children. It is destroying our households, and it destroys our society. So maybe we can ask, through the Chair, for them to give us a report, what would they like to see us do in legislation.

Thank you very much, Mr. Chairman.

Mr. MCHENRY. Without objection, I think the committee would accept any further testimony you want to add or recommendations in particular that you would like to add to your testimony today. Without objection, that is ordered.

At this time, I would like to recognize my colleague from North Carolina, my neighbor to the north and west, Ms. Foxx.

Ms. FOXX. Thank you, Mr. Chairman. I am going to ask you all to answer, with one word, a question, each one of you. And then I want to ask a question.

Mr. Burns said that the methamphetamine problem is not as great as cocaine and heroin. I just want you to go down the line and say, do you agree or disagree? I only want one word from each one of you. So start with Dr. Young.

Ms. YOUNG. Boy, that is so hard.

Ms. FOXX. One word.

Ms. YOUNG. No. I would not agree. Wait. Excuse me. Would you rephrase? Because I want to make sure I am answering the right way. He said it was not as bad a problem? Depending on how you phrase it, I would say no. That is not correct.

Ms. BROWN. I agree with Ms. Young—Dr. Young.

Ms. BAKER. Do you agree or disagree with Mr. Burns?

Ms. BROWN. I disagree. I think it an epidemic of epidemic proportions.

Mr. MCHENRY. One word. Mrs. Baker.

Ms. BAKER. Disagree.

Mr. BYERS. Disagree.

Ms. DUNN. I would disagree.

Chief OWENS. Disagree.

Mr. SHOOK. Disagree.

Ms. FOXX. Thank you very much. So let the record show everybody disagreed.

Sheriff Shook, could you tell us what, if any, Federal programs or State programs have been helpful to you and what you have been doing to fight the meth problem?

Sheriff SHOOK. The formation of our meth task force through the State Bureau of Investigationis partnering with other county agencies, city agencies, the ATF, DEA and the U.S. Attorney's Office. We have also gotten a grant in our county, the endangered children's grant. That has helped us team with our mental health facilities, our Department of Social Services, and all the community groups combined have really made a difference because we have

also gotten another grant that our Department of Mental Health is working with, Meth Affects Families, and they are doing a very good job working with the parents trying to reunite them with the children.

I personally got to go to one of the counseling sessions with one of their clients. She was asked to bring someone that made an impact on her life with her meth problem, and she chose me to come. That was a very big honor for me.

But just to see the communities pulling together and getting these Federal and State grants, that is what we have to have to fight this problem. And we all have to pull together, local, State and nationwide.

Ms. FOXX. What you're saying is that there is an attempt at a comprehensive approach based on the collaboration that has gone on and that has been the message that we have been hearing from folks?

Sheriff SHOOK. That is correct.

Ms. FOXX. Thank you very much.

Mr. MCHENRY. Thank you, Ms. Foxx. At this time, I just want to, on behalf of the whole Committee on Government Reform and the subcommittee here today, I would like to thank you so much for taking time out of your schedules. It is wonderful to actually have people in the front lines here giving real recommendations and real policy objectives in the needs of our local community. It is very refreshing. It is about this time in Washington on a Tuesday when most Members of Congress are ready to get back home and back to reality, and I appreciate you all injecting a dose of reality to our day here in Congress. And I sure appreciate your testimony. Thanks so much. You're dismissed. And at this time, this meeting is adjourned.

[Whereupon, at 5:21 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

The Meth Epidemic in America

Two Surveys of U.S. Counties:
The Criminal Effect of Meth on Communities
The Impact of Meth on Children

July 5, 2005

Angelo D. Kyle
NACo President

Bill Hansell
NACo President-Elect

Executive Summary

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

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

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

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

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

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

The Criminal Effect of Meth on Communities

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

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

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

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

The Impact of Meth on Children

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

Survey 1

The Criminal Effect of Meth on Communities' Law Enforcement Agencies

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

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

Increases in Arrests involving Methamphetamines

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

Increases during last five years

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

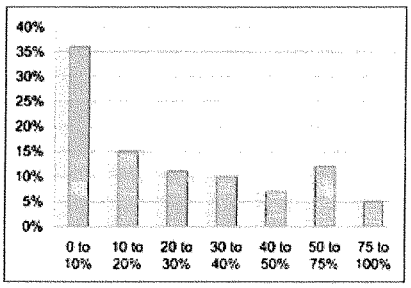
The states reporting the highest percentage increase in meth related arrests starting 5 years ago are Arizona, Arkansas, Florida, Indiana, Iowa, Louisiana, Minnesota, Mississippi, Nevada, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Washington and Wyoming, all reporting a 100% increase in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

Increases during last three years

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

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

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



Increases during the last year

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

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

Total Methamphetamine Related Arrests

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

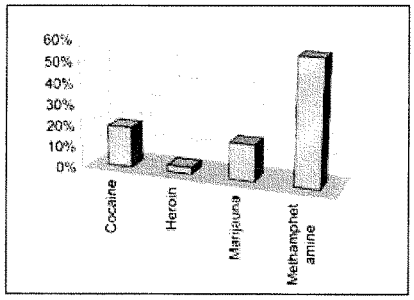
On the national level, the federal government still considers marijuana as the number one drug problem in America, but county law enforcement officials have a different perspective on this ranking. With the growth of this drug from the rural areas of the western and northwestern regions of this country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

What is the Primary Drug Problem in Your County?

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

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

Figure 2: Primary Drug Problem



Methamphetamine Impact on Jails

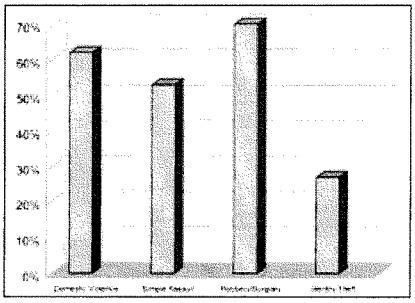
The growth of the use and addiction to methamphetamines has occurred so fast and to such a degree that many local governments are scrambling to catch up. Only 16% of the law enforcement officials report that their county either facilitates or sponsors a meth rehabilitation center or program, while 81%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

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

Crimes Increasing Because of Meth

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

Figure 3: Increase in Crimes Because of Meth Use



Impact of Meth on Law Enforcement Activities

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

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

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

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

Survey 2

The Impact of Meth on Children Out of Home Placement

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

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

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

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

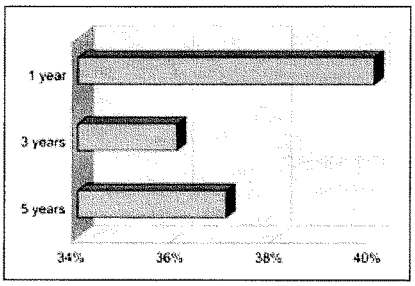
In order to determine the impact of this drug on children of the meth epidemic, the National Association of Counties conducted a survey of county child welfare officials in the 13 states in the country where this activity is administered at the county level. The telephone survey was conducted by Research,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

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

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

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

Figure 4: Increase in Out of Home Placements



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

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

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

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

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

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

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

The Methamphetamine Epidemic

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

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

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

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

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

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

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

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

The Criminal Effect of Meth on Communities' Law Enforcement

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

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

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

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

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

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

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

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

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

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

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

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

The Impact of Meth on Children Out of Home Placement

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

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

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

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

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

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

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

Responding County Law Enforcement Agencies

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

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

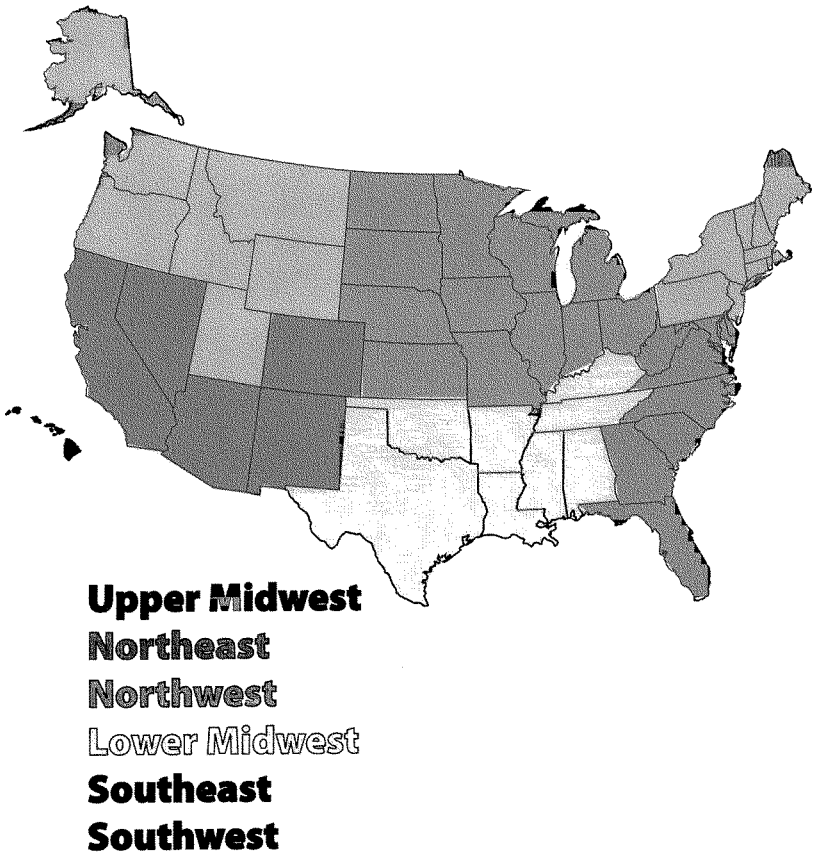
By Regions	
Upper Midwest	176
Northeast	24
Northwest	73
Lower Midwest	113
Southeast	69
Southwest	45
Total	**500**

Responding Child Welfare Agencies

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

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

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


Upper Midwest
Northeast
Northwest
Lower Midwest
Southeast
Southwest

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

August 8, 2005

The Honorable Mark E. Souder
Chairman
Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
U.S. House of Representatives
Rayburn House Office Building B-377
Washington, DC 20515

Dear Chairman Souder:

Thank you for the opportunity to testify on behalf of the Administration at your Subcommittee's July 26, 2005 hearing entitled "Fighting Meth in America's Heartland". Please find enclosed answers to your questions for the written record. I hope they prove to be helpful in the work of the Subcommittee.

Thank you again for your dedication on the issue of drug control. I appreciate your valuable insights and perspectives. If I may be of further assistance, please contact me directly at (202) 395-4694 or have your staff contact the Office of Legislative Affairs staff at (202) 395-6602.

Respectfully,

Scott Burns
Deputy Director
State and Local Affairs

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

"Fighting Meth in America's Heartland"

July 26, 2005

FOLLOW-UP QUESTIONS FOR THE RECORD FOR HON. SCOTT BURNS, DEPUTY DIRECTOR, OFFICE OF STATE AND LOCAL AFFAIRS, OFFICE OF NATIONAL DRUG CONTROL POLICY

1. Through this Subcommittee's work we have learned that Mexico is one of the largest methamphetamine producing countries in the world. Many of the "superlabs" are located in Northern Mexico and produce much of the meth that is smuggled into and consumed in the U.S. Yet, even though this is widely known, the President still certifies every year that Mexico is a nation that fights drugs.

    a. Do you believe that Mexico has not "demonstrably failed" to cooperate in preventing meth production and the illegal diversion of meth precursor chemicals?

The Government of Mexico (GOM) has taken significant steps to cooperate in preventing methamphetamine production and the illegal diversion of precursor chemicals. GOM law enforcement authorities are working with DEA personnel in training and equipping methamphetamine-specialized personnel, investigating and destroying methamphetamine labs, and interdicting precursor chemicals. DEA has been providing diversion and clandestine lab cleanup training courses for GOM law enforcement elements, and will continue to do so.

According to some GOM estimates, since December 2000, GOM authorities have seized dozens of laboratories and approximately 49.5 million pseudoephedrine pills. Also, the GOM has been jointly working with DEA to identify and investigate attempts to divert pseudoephedrine. These investigations led to the seizure of over four metric tons of pseudoephedrine destined for illicit methamphetamine production and prevented the manufacture of nearly 2.5 metric tons of methamphetamine.

    b. Do you believe that Mexico has "fully cooperated" with respect to preventing meth production and the illegal diversion of meth precursor chemicals?

Mexico has cooperated to the extent of its ability to prevent methamphetamine production. The GOM has begun implementing voluntary controls on pseudoephedrine in cooperation with industry and is considering other controls. Those implemented now, or planned soon, include:

- Limiting retail sales to pharmacies.
- Limiting pharmacy sale quantities to three boxes of approximately 9 grams per individual (effective October 15, 2004).

- Convincing distributors to voluntarily agree to limit sales to customers with legitimate commercial needs.
- Closely monitoring the issuance of import permits. Mexico has recently begun efforts to impose import quotas on pseudoephedrine based on estimates of legitimate national needs which are based on studies conducted by the Ministry of Health.

Recently, the GOM, working hand-in-hand with DEA officials, took further steps to ensure that pseudoephedrine from Hong Kong will not be diverted to traffickers in Mexico. On January 24, 2005, Hong Kong authorities agreed to stop exports of pseudoephedrine pharmaceutical products to Mexico and Panama unless a valid permit for these exports has been issued by the importing country. This pre-export notification, implemented in April, is a major step for Hong Kong because the 1988 UN Convention controlling pseudoephedrine does not require nations to control these pharmaceutical products. This arrangement should impact shipments of these products to Mexico from Hong Kong since most of the shipments identified involved consignees who either did not exist or not had valid permits to import these products.

c. Do you believe that India, China, and Germany, the three major pseudoephedrine -producing countries, have either "fully cooperated" or not "demonstrably failed" to cooperate with us. With respect to preventing precursor diversion?

India, China and Germany have cooperated to the extent of their treaty obligations under the 1988 convention.

India has gone beyond the obligations of the 1988 convention by agreeing to provide pre-export notices for pharmaceutical products containing ephedrine and pseudoephedrine that are not controlled by the treaty. Additionally, DEA uses a "Letter of No Objection" (LONO) process to notify the exporting country that inbound shipment has been approved by the DEA. The DEA has a Diversion Investigator present in India.

Currently, DEA diversion personnel are working with China to establish the same pre-export notification process that India uses for pharmaceutical products containing ephedrine and pseudoephedrine. The LONO process is used with China for raw ephedrine, raw pseudoephedrine, and single-entity tablets. The DEA is scheduled to have a Diversion Investigator in place by August 5, 2005.

Germany has always been very cooperative and diversion issues have not been a significant problem. They manufacture and export raw material ephedrine and pseudoephedrine only, which is covered under the 1988 convention. Additionally, we do receive pre-export notices for shipments to the United States. The DEA has a Diversion Investigator present in Germany.

2. Is it true that the Media Campaign, which is administered by ONDCP, only recently entered into a contract to produce about $1 million worth of ads targeted at meth? Why hasn't the Media Campaign done more to deal with this problem?

The goal of ONDCP's National Youth Anti-Drug Media Campaign is to prevent and reduce *youth* drug use. The Campaign directly addresses those illicit substances that are most prevalent

among our youth and methamphetamine is not one of those substances. Even more encouraging is that more young people have decided not to use methamphetamine—our latest data tells us that methamphetamine use among teens is down 25 percent over the past three years making it 1.1 percent of all youth drug use.

Nevertheless, we have taken the unprecedented step of directly funding the Partnership for Drug-Free America to produce new anti-meth ads to ensure that we address the impact of methamphetamine on the entire community, including youth. On February 3, we started discussions with PDFA and on June 20, the Media Campaign contracted with the Partnership for a Drug-Free America on a sole-source basis to develop new anti-meth advertisements. These new advertisements are being designed to help mobilize communities against the methamphetamine threat.

With our accelerated schedule, we anticipate that these hard-hitting new advertisements will be ready for airing as soon as late November of this year, and would be launched regionally in key methamphetamine-affected areas. The basis for this ONDCP initiative is that while teens seldom use methamphetamine, it nevertheless has a substantial negative impact on youth. The manufacture, trafficking, and use of methamphetamine puts youth at risk because of the poisonings, fires and explosions, environmental contamination, dysfunctional families, risk of abuse and neglect, and other challenges associated with methamphetamine. Although PDFA has developed other methamphetamine advertisements to build awareness of the methamphetamine problem, these new advertisements will take the message to a new level by directly engaging communities in fighting the methamphetamine problem. We hope the new advertisements will complement the efforts of state and local law enforcement and equip concerned citizens and parents with new tools to take action to protect their communities.

Although these will be the first advertisements the Media Campaign has developed on methamphetamine, the Media Campaign has long addressed methamphetamine and other drugs in substantive ways:

- All Campaign websites (for teens and parents) include the latest scientific information about the risks of methamphetamine, including a special feature entitled "Talk to Your Teen About Meth" on the website for parents, TheAntiDrug.com.

- The Campaign has conducted two briefings for journalists and entertainment industry writers on methamphetamine, one as recently as three months ago in collaboration with the Writer's Guild, which drew more than 120 writers and producers.

- The Campaign's strategy for parents, who remain the most influential force in the lives of teens, is to deliver a clear and consistent no-use message and to monitor teens' behavior. Research shows that such actions significantly reduce the chance that teens will use drugs of any kind, including marijuana, cocaine, ecstasy, alcohol, heroin, or methamphetamine.

- The Campaign has provided advertising time for anti-meth advertisements through its media "match" program, including PDFA methamphetamine advertisements.

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

"Fighting Meth in American's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

July 26, 2005

Follow-UP Questions for Ms. Betsy Dunn, Investigator
Tennessee Department of Children's Services
Child Protective Services Division

Question:

1. In your opinion, how well coordinated are the various federal grants and assistance programs which deal with Meth enforcement (For example, Byrne, COPS "Meth Hot Spots", OCDETF, RISS, and HIDTA)? Does Congress need to provide a mechanism to better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with-ONDCP, the Justice Department, COPS, OCDETF or DEA?

Answer:

As it is not my area of expertise, I don't believe it is appropriate for me to respond.

Question:

2. From your agency's perspective, what legislative or programmatic changes would you recommend to better support victims or problems related to the meth epidemic?

Answer:

1. Development of evidence based treatment modalities. The success rate in treatment meth addiction is very low.

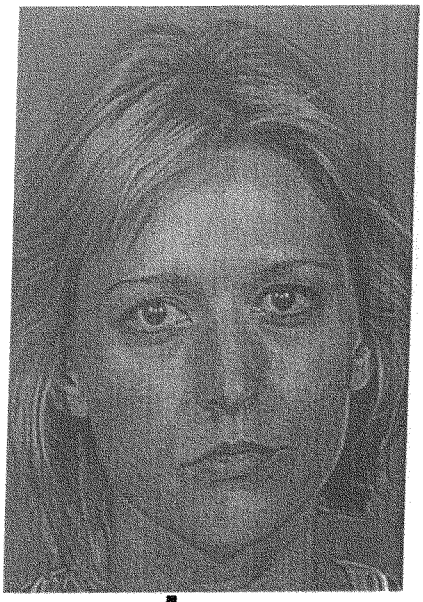
2. National restriction of access to ingredients particularly pseudoephderine. This is being done slowly state by state but as long as a perpetrator can cross a state line and get what they need, these laws are limited in effectiveness.

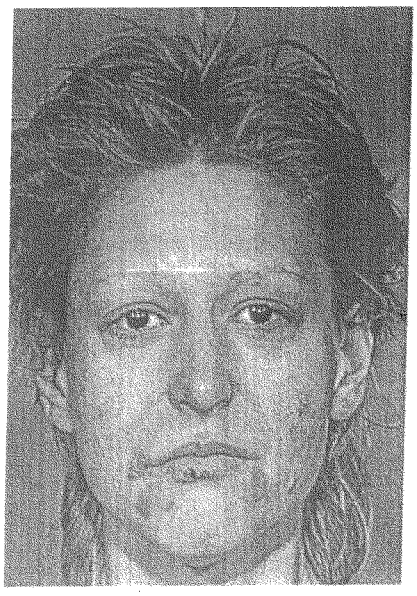
3. Engage the pharmaceutical industry in voluntary control of access or looking at ways to alter drugs so that they are no long viable as agents for meth development.

4. Support of local law enforcement in serious penalties particularly in situations where children are exposed to methamphetamine production.

5. Assistance to states in cleaning up meth sites.

Before and After





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

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare agencies"

July 26, 2005

FOLLOW-UP QUESTIONS FOR MS. FREIDA BAKER,
DEPUTY DIRECTOR, FAMILY AND CHILDREN'S SERVICES,
ALABAMA DEPARTMENT OF HUMAN RESOURCES

1. In your statement, you mention Governor Riley's Faith-Based Substance Abuse Treatment Advisory council. How is the council created? What are the advisory council's goals?

Response: The Faith-Based Substance Abuse Treatment Advisory Council was established by the Governor's Office of Faith-Based & Community Initiatives for the purpose of increasing partnerships between faith-based substance abuse treatment providers and the state and federal government. A group of providers with strong track records and demonstrated outcomes was selected. They have met with Governor Riley and other senior officials from the Alabama Dept. of Corrections, Alabama Pardons & Paroles, CADCA, the Administrative Office of the Courts and the Alabama Department of Mental Health, which handles all of the SAMHSA funds that come into the State.

The Council is currently working with the Alabama Department of Mental Health in a review of their standards for certification to make sure they are free from barriers to faith and community based organizations. An important goal of this group was to develop state standards that faith-based programs could adhere to that would allow them to apply for faith-based funding and to see that adequate treatment was being done. Ultimately, they are also looking for strategic ways they can be of help in addressing the problems of substance abuse treatment within the state.

2. The "Shoulder Ministries", as you mentioned, is a faith-based drug treatment program, certified by the Alabama Department of Mental Health. I understand they serve almost 120 addicts per year. Could you tell us about the role the "Shoulder" serves in your efforts to reach as many drug addicts as possible?

Response: The Shoulder offers a partial residential Intensive Outpatient Program and a transitional Residential Rehabilitation Program, which includes a structured Aftercare Program. In addition to its regular treatment programs as described below, The Shoulder provides outreach education programs to the general public, schools and universities in Mobile, Baldwin and surrounding South Alabama counties. This service provides general addiction education, aids in the identification of those exhibiting signs and symptoms of alcoholism and chemical dependency, as well as guidance for treatment of these conditions.

Each program lasts a minimum of eight weeks. If a client has a stable and safe home environment, the client may opt to continue to live at home and participate in the IOP Monday through Friday nights. For those male clients who do not have a safe or appropriate home environment, The Shoulder offers a partial residential program. Clients who reside there work during the day and participate in treatment each evening and on weekends.

At the onset of each program, the staff works with each client to develop an individualized treatment plan. This includes individual and group therapy, spiritual development, substance education, family group therapy, and 12 Step meetings. Clients also receive the advantage of resources available from the community, such as literacy training, financial budgeting classes, GED preparation, and the like.

The Shoulder maintains a strict drug and alcohol-free environment. Clients are regularly tested to insure they are maintaining their sobriety. A Family Practice, Certified Nurse Practitioner is present on staff to assist clients as needed with healthcare problems.

Treatment takes place each evening. Clients are required to work during the day. In the event of employment difficulties, The Shoulder will provide a list of potential employers. It is the client's responsibility to find employment and transportation to and from his job. Research and experience have shown that gainful employment helps clients develop confidence, self-worth, job skills, money management skills and personal responsibility.

After finishing the Intensive Outpatient Program, clients have two options open to them: a Residential Rehabilitation program onsite including an Aftercare Program, or returning home and participating in aftercare on-site.

3. The work of the "Shoulder" appears to be very similar to Teen Challenge – a faith-based drug treatment program with facilities throughout the nation. Recently, I asked the various directors of Teen Challenge programs to tell us how many participants enter their programs because of meth addiction. The results from their informal survey were staggering. In some facilities, over 90% of the participants were meth addicted.

Response: Philip Drane explained that "most of the Teen Challenge programs are a minimum of six months to one year in length. They are a Christ-Centered treatment program and address the treatment process in similar ways as The Shoulder. Our primary treatment program is a minimum of eight weeks. The Shoulder also has a state certified Residential Rehabilitation Program, more commonly referred to as a Halfway House. We accept people into our Halfway House who have successfully completed a full term treatment program whether at The Shoulder or some other state certified treatment program. Individuals can stay in the Halfway House from a minimum of eight weeks to a maximum of one year. The Halfway House provides a continued structured living environment with fewer restraints in terms of coming and going. Not only are the halfway house participants required to work, they participate in weekly aftercare group sessions, life skills programs, one on one counseling sessions, GED programs where necessary, and participation in 12-Step meetings throughout the community. As you can see, while our programs are structured differently, there are similarities between Teen Challenge and The Shoulder programs."

a. Are many Alabama programs similarly overwhelmed with meth cases?

Response: At Pardons & Paroles, for example, over 85% of cases heard have an addiction component. Two years ago several cases a month appeared to involve crystal meth. At present, it is not unusual to have several cases a day involving meth. Meth addicts typically aren't released until the inmate has been incarcerated at least a year and successfully completed a significant substance abuse program (six months minimum). They recommend that those paroled enter a residential program and have regular drug screening.

Phillip Drane, Executive Director of the Shoulder, states "Over the 18 years that we have been providing treatment we have found very few individuals who were addicted and/or abusing only one substance including alcohol. What we have seen over the last three years is that more and more of those coming to treatment are presenting with methamphetamine dependence in addition to other drugs and or alcohol. I can say without question that methamphetamine is being used more frequently and seems to be more readily available than ever in the past."

The Pathfinder, another treatment resource, has seen an increase in Meth cases in the past two years, with average of 30% to 50% of clients being Meth abusers at any one time.

One trend is that most of their clients now tend to be multiple drug abusers (polysubstance abuse) with a combination of Meth, crack, pills, pot and alcohol. They report that they seldom see anyone who has a single drug of choice. The other interesting trend is that, two years ago, Meth addicts came primarily from the rural counties. Today staff at Pathfinder are seeing more and more clients from the larger metro areas of the state. The Meth epidemic is spreading across our state.

b. Early in your testimony, you mention that state mental health programs face the difficulty of hiring experienced staff. Do you find that working with faith-based AND community groups helps with this particular issue?

Response: The Shoulder reports that, for example, they work closely with faith-based and non faith-based mental health centers and treatment programs. They report that finding counselors with credentials and experience is becoming more and more difficult. This is not just a mental health or a faith-based issue. The basic problem is that the Public Mental Health System, particularly treatment programs, do not have the resources to pay a competitive wage to good counselors. Many counselors are working for large hospitals, school systems and going into private practice.

Relationships with faith-based and community groups help with context and are important in terms of information, referral, and best practices. However, the issues around stress, wages, and professional climate are barriers in both government and faith-community based hiring and retention of staff.

4. From your program's perspective, what legislative or programmatic changes would you recommend to better support victims or problems associated with the meth epidemic?

Response: Statistics indicate that the vast majority, as high as 85%, of those incarcerated in our county or state prison system are there for some drug or alcohol related offense. If the primary problem of an individual is substance abuse addiction, incarceration in and of itself will not solve the issue. Requiring those defendants that are guilty of a drug related offense to participate in a certified long-term treatment program would provide more benefit to the community, and to that individual, than incarceration. The current problem with many "drug court" programs is that the court systems are sentencing more people to the "drug court programs" than the drug court is capable of handling appropriately. Drug Court programs can and do work, but must be properly structured, properly staffed and properly run.

The Alabama Department of Corrections has a particularly good substance abuse treatment program, known as "Crime Bill". However, there is as much as a two-year waiting period for an inmate to be admitted to that program. With the pressure to empty our state prisons, many non-violent offenders are being paroled before they have an opportunity to participate in the Crime Bill or the Therapeutic Community's substance abuse treatment programs. All of this requires more money and more bed space for residential programs.

One other issue that the state might address would be reviewing the requirements for the health insurance companies licensed in the State of Alabama. Approximately 10 years ago, the health insurance industry began cutting services because of concern about profits. Some of the first reductions were in substance abuse treatment. Many health insurance policies will provide for a detox program but in most cases will not provide for treatment or for treatment lasting no more than 7-10 days. Effective treatment cannot take place in less than approximately six weeks.

Mr. Drane suggests that the Alabama Insurance Commission should require that anyone selling health insurance in Alabama be required to provide substance abuse treatment for at least six weeks. This should reduce both health care costs and crime. He adds "From a profit point of view, it is my personal feeling, that insurance companies would realize more profit because the more people who receive treatment, the less accidents there will be, and fewer substance abuse medical related problems will have to be paid by those insurance companies."

John Schafer of Pathfinder recommends increases in funding for women and women with children. The Pathfinder can serve 12 women and 26 men, but has no funding or financial resources to add additional beds for women with children. He believes it would be beneficial to attempt to reunite families in a safe, drug-free environment, which would require additional staff, training for staff, and proper living quarters to house women and children.

City of Titusville
Police Department
"Birthplace of the Oil Industry"

323 N. Franklin Street
Titusville, PA 16354
Phone: (814) 827-1890
FAX: (814) 827-4219

Gary L. Thomas
Interim Chief

Additional Testimony of

Donald D. Owens
Chief of Police, City of Titusville, Pennsylvania

Follow-up answers to questions requested by the
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Of the
House Committee on Government Reform

Hearing on

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

submitted
August 31, 2005

1. Have your agencies received funding from DEA's Hazardous Waste Disposal reimbursement program? How would you propose to improve the program?

Titusville Police Department is aware of a reimbursement program through the Environmental Protection Agency, but not the one through the DEA. We have since attempted to research the DEA program and were not able to find any information about it on the DEA website. We did find a fact sheet on the Office of Justice Programs website, but no information on how to apply for funds.

If the DEA program is similar to the EPA program, the way to improve the programs would be to simplify the application procedure. The old saying "it takes a Philadelphia lawyer to figure it out" applies to the application process. It is nice that federal agencies want to help smaller departments, but it feels like we are jumping through hoops to get nowhere most of the time.

2. Have your agencies received any training from DEA on meth lab investigations and/or clean up? Is that paid for by DEA, in whole or part? How easy is it for your agencies to get that kind of training?

As far as we are aware, no Titusville Police officers have attended a training sponsored by the DEA. It is not very easy for our department to get this kind of training. Located in the corner of northwest Pennsylvania, we are not "conveniently" located next to anything. Most of the trainings have been too far away to make it feasible for us to attend. In addition, we do not receive notices of trainings in a timely manner. As an example, there was a DEA meth seminar in Harrisburg, PA, which we could have attended. We did not receive word that it was taking place until the day it was scheduled. It seems like larger agencies like the DEA want to deal with the PA Attorney General's Office or the Pennsylvania State Police and not the small departments. The problem with that is that the small departments, like Titusville, are much more on the front lines of this fight against meth. And, although we do have a good working relationship with the Attorney General's Office and the PSP for the investigation of labs, there is a lack of communication regarding training opportunities.

3. Have your agencies ever received training from the National Guard's counterdrug schools? Has that training ever been useful for meth lab investigations?

Titusville Police Department had planned to send an officer to Ft. Indiantown Gap, Pennsylvania, for methamphetamine training the last week of August, but he was unable to attend due to court commitments that could not be continued. This training would be very valuable to our department; however manpower issues make it difficult to send officers for week-long training sessions.

4. How effective have the various drug court programs been in dealing with problems like meth abuse and addiction? How would you like to see these programs improved?

None of the counties in our immediate area have drug courts, so we don't have first hand knowledge of the effectiveness of that approach to drug abuse and addiction. However, we have read information and seen programs about other counties with serious methamphetamine problems that do have drug courts and the information has been very positive. Titusville Police feel that drug courts may be a very viable option to dealing with methamphetamine in our area. As stated in our previous testimony before the subcommittee, we feel that there is a discrepancy in the way drug cases are treated from one county to the next. Also, there is a certain amount of frustration with the judicial system where cases are pled to a lesser offense and repeat offenders are given probation sentences. Then, while on probation, individuals are found to be using methamphetamine over and over again, but their probation is never revoked. A drug court would provide tighter restrictions and more intense supervision and accountability for offenders. Our experience has shown that those addicts who were able to get off meth and stay of meth did so by removing themselves from that environment.

Although funding opportunities have been presented by the Department of Justice on a federal level and the Pennsylvania Commission on Crime and Delinquency on a state level, the judicial system in Crawford County has never seemed to be interested in establishing a drug court.

5. How are meth lab clean-up costs allocated within your states? Does the state government pick up the tab, or do local counties or agencies have to pay for it? What kind of support have you gotten from the U.S. EPA or other federal agencies?

Pennsylvania does not yet have a mandated "clean-up" requirement for methamphetamine labs. When a lab is discovered, the Pennsylvania State Police Clandestine Lab Response Team is brought in to search the site, collect evidence and secure any chemicals or drugs present. To date, the State Police have been covering the cost for CLRT responses and disposal of the chemicals, which allows small local law enforcement agencies to utilize this valuable resource. Once the team has removed evidence and disposed

of any chemicals that were found, the site is posted as a "potentially contaminated site". The property owner then becomes responsible for any clean-up of the site, which again is not mandated by the state. Therefore, the police could seize a lab at a rental property on Monday and the landlord could remove the signs and rent the place on Tuesday and the new tenants would never know that there was a contamination hazard in the residence.

6. In your opinion, how well coordinated are the various federal grant and assistance programs which deal with meth enforcement (for example, Byrne, COPS "Meth Hot Spots", OCDETF, RISS, and HIDTA)? Does Congress need to provide a mechanism to better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with – ONDCP, the Justice Department, COPS, OCDETF, or DEA?

In our opinion, these programs are not very well coordinated. As an example, our grant writer went looking for funding from the agencies listed above and found almost no information at all about methamphetamine funding. The Byrne formula money is filtered through the state; we found a statement where Byrne discretionary funding had been eliminated. No information on how to apply for COPS "Meth Hot Spots" funding was found. Previous COPS meth funding has all been listed as "congressionally earmarked funds" which means that there is no competitive grant period. We looked for OCDETF and again, found a fact sheet about the program but no information on how to apply, who is eligible for funding, etc. As for the HIDTA, the DEA and other federal agencies don't seem interested in the small mom & pop labs, only the Mexican Cartel trafficking. Titusville's meth problem is local labs and we don't meet the criteria for a HIDTA. As for being a part of RISS, we have looked into it and may apply. Part of our problem with this program, after reading the guidelines, is again a manpower issue.

We don't know if congress needs to create another mechanism for coordinating these funds or if these organizations just maybe need to find a better way of providing information to smaller departments. We live in an age of tremendous technology and increased electronic communications and yet, we can't find the information we need on websites.

As far as having one agency control the funding, that may be better than creating a new system. We have always received excellent assistance and cooperation from the COPS office for the grants we have received from them. Except for some frustration with passwords, they have made filing reports and submitting applications more efficient through online services. We would suggest that they, or the DOJ, coordinate all funding. DOJ and COPS sites are informative and easily accessible for grant information. As indicated by some of their testimony at the July 26, 2005, hearing, ONDCP and DEA seem out of touch with the meth problem in the country. And as stated, we found it difficult to find any funding information on their websites.

7. What would the result be if court sentences were treatment based rather than jail time based? Would this legal approach be more effective at combating the meth addiction and "cooking" problem?

Treatment or jail time? Either may be effective in combating meth addiction and cooking problems. What we have found is that even when on probation and facing jail time, addicts will still use methamphetamine. Often court sentences are under two years, which means the individuals serve their time in county jail. Many meth addicts have said that they can put in a few months easily and then just go back to their meth use when they get out. Many meth addicts have also gone to treatment programs which are court ordered. They attend their meetings for 30 or 60 days and then go right back into the drug use when they start hanging with their friends or family again. The key to addressing these problems is long-term, intensely monitored supervision. You need to take the addict or the cook out of their environment. If you can do that through court supervised treatment programs, then that is an option.

8. How much of a burden is it for your officers to report meth lab seizures to DEA's EPIC intelligence center? What could be done to make this reporting easier?

Our department does not report labs directly to the EPIC. The reports are filed by the Pennsylvania State Police Clandestine Lab Response Team. We have heard that many of our labs do not meet the criteria for a lab under the DEA guidelines and therefore aren't being counted. Again, they seem to be only looking for the super labs. Maybe they should reevaluate their criteria on labs. Whereas small labs make up only 20% of the meth production for the country, for Titusville and much of rural America they make up 100% of the meth production.

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

"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

Follow-Up Questions to the Hearing on July 26, 2005

1. In your opinion, how well coordinated are the various federal gnat and assistance programs which deal with meth enforcement (for example, Byrne, COPS "Meth Hot Spits", OCDETF, RISS, and HIDTA)? Does congress need to provide a mechanism to better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with – ONDCP, the Justice Department, CIOPS, OCDETF or DEA?

As for the HIDTA (High Intensity Drug Trafficking Area) the programs were very well coordinated in dealing with methamphetamine enforcement. There were meth enforcement strategies planned and mapped out annually. Each had to be submitted and followed and results were documented quarterly. The coordination and cooperation between the local, state and federal agencies within the LA HIDTA was remarkable. The funding for the LA HIDTA, directed from ONDCP Office of National Drug Control Policy was divided between Orange, Los Angeles, Riverside and San Bernardino counties.

Byrne Grant monies were sent out to individual states who in turn provided funding to assist with programs within their state. I believe some of the DEC programs funding within California is Byrne Grant money.

COPS funding has provided funding for agencies to enforcement meth programs, as well as, providing funds to put together and support training conferences such as the First National Drug Endangered Children Conference that was held in Denver last year. I have attended other conferences that were funded by COPS in an effort to coordinate the methamphetamine assault.

A lot of the major investigations throughout the country have been funded through OCDETF, Organized Crime Drug Enforcement Task Force funds. Enabling agencies with limited funding to pursue the offenders, that they normally wouldn't be able to pursue.

Each of these have a different hierarchy and different hoops to jump through. It would be great if they were all under one authority, so that same guidelines were in place for all funding issues. ONDCP has been a very effective tool in coordinating the HIDTA Initiatives throughout the country; thus, in my humble opinion it would be ideal for all to be under their direction. Spreading it out among many agencies can add the political fervor of that particular agency, creating issues before funding can occur.

2. From your county's perspective, what legislative or programmatic changes would you recommend to better support victims or problems related to the meth epidemic?

There are several ways in which Riverside County would like to see the Federal Government approach the problem of the meth epidemic. First, there needs to be ongoing sustainable funding for the programs that we know work. The federal government provides many grants for programs like DEC, Drug Endangered Children, and Drug Courts, but these grant funds are usually only for three year periods and counties find it difficult to impossible to provide the continued funding for these programs.

In Riverside County, we began our DEC program in 1998 and as a result, we have seen a decline in the number of meth labs in our area as the drug community has become aware of our multidisciplinary aggressive approach to meth labs. Unfortunately, the result of fewer meth labs for us in California means that the drug makers have just moved on to other states. The federal government should provide funding at a national level for every state to have a multidisciplinary approach to addressing this problem. When the agencies work together and pool the resources, it becomes a more effective way to deal with the meth epidemic.

Drug Courts are another program that we have been utilizing in Riverside County that we know are successful. This funding also comes in the form of three year grants. The Drug Court program also utilizes a multidisciplinary approach to handling this problem by providing intensive drug treatment services through a substance abuse program, a child welfare worker to provide other family service needs, and a case manager who provides intensive daily contact with the offender to ensure their cooperation and participation in treatment. If the offender fails to participate, there are legal consequences that are immediate and punitive.

Another area in which the federal government could make changes is in providing national legislation that restricts the sale, distribution and import of the medications that contain the ingredients used for the manufacturing of meth. The government would also need to implement criminal penalties for violating any of these same activities at a national level and not wait for states to do this through state legislation.

Finally, we believe that there is a need for a national campaign about methamphetamine and its effects on individuals, their health, the children and our communities. This has already been done with cigarettes and alcohol so the model for achieving this is already in place. Providing this form of education provides our communities with the preventative knowledge necessary to identify users early and get them referred to the appropriate agencies before their use becomes a bigger problem.

Dan Good
Sheriff

Rutherford County Sheriff's Office

C.Philip Byers
Chief Deputy

TO: Members, Subcommittee on Criminal Justice, Drug Policy and Human Resources

FROM: Chief Deputy C. Philip Byers, Rutherford County Sheriff's Office (North Carolina)

DATE: August 29, 2005

RE: Follow-Up Questions-"Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

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1. ***Have your agencies received funding from DEA's Hazardous Waste Disposal reimbursement program? How would you propose to improve that program?***

The Rutherford County Sheriff's Office does not receive money directly from the DEA's Hazardous Waste Disposal reimbursement program. In North Carolina, the State Bureau of Investigation is currently handling the actual arrangements for our clean up activities. We are indirectly the beneficiary of the federal funds set aside for meth lab clean-up allocated by the Department of Justice (Drug Enforcement Administration).

The North Carolina State Bureau of Investigations may have suggestions on improving the current reimbursement program. If not for the federal funding for meth lab clean-up, our local government budget would be tremendously over-burdened.

2. ***Have your agencies received any training from DEA on meth lab investigations and/or clean up? Is that paid for by DEA, in whole or in part? How easy is it for your agencies to get that kind of training?***

198 North Washington Street, Rutherfordton, NC 28139 (828) 287-6247

Yes. The Rutherford County Sheriff's Office has received training from the DEA in the following: (Narcotics Investigations, Advanced Narcotic Investigations, Clan Lab Certification and Annual Clan Lab Recertification.)

The training is paid for by the DEA, generally with a sponsoring local agency. The Clan Lab Certification class also provides several thousand dollars of equipment that our agency would normally be unable to purchase.

The training provided by the DEA is highly sought after and only offered a few times each year. Most of the classes have a long waiting list of prospective students. More funding is needed to allow the DEA to offer additional classes throughout the year.

3. ***Have your agencies ever received training from the National Guard's counterdrug schools? Has that training ever been useful for meth lab investigations?***

Yes. Prior to 2005, the Rutherford County Sheriff's Office had received training from the National Guard and is as follows: (Counter Drug Special Response Team, Advanced Counter Drug SRT, Counter Drug K-9, Indoor Grow Operations, Clandestine Labs, and Basic Narcotics.) The specific training we have received has been provided by the Mid-Atlantic Narcotic Training Academy at the directive of the Counter Drug Coordinator of the North Carolina National Guard Counter Drug Task Force (NC CDTF). The training is provided free of charge to law enforcement agencies as the funding is provided by the Governor's Crime Commission and the Department of Crime Control and Public Safety. Funding for the schools has been greatly reduced for (2005-06), thus limiting the available courses. There is currently no funding planned for the training beyond the fiscal year 2006.

Prior training provided by the National Guard has been useful in fighting meth and understanding the apprehension and investigations of Clandestine Labs. Local law enforcement would greatly benefit from additional training opportunities provided by the North Carolina National Guard Counter Drug Task Force.

4. ***How effective have the various drug court programs been in dealing with problems like meth abuse and addiction? How would you like to see the program improved?***

In Rutherford County, we have no drug court programs. In state court, we handle drug cases much the same as other felony charges. Our state court system is failing miserably in dealing with meth abuse and addiction. The Rutherford County Sheriff's Office is currently working with the U.S. Attorney's Office to seek federal prosecution in most of our meth cases. We have found that federal prosecution is much more punitive and the federal prison system is better prepared to deal with meth addiction.

Rutherford County must develop a drug court program in order to deal with meth addiction. This again brings us to the funding issue which will more than likely be addressed by the federal government. Funding for a drug court and a comprehensive mental health approach will greatly improve our current system of handling meth cases in the state court system.

5. ***How are meth lab clean-up cost allocated within your states? Does the state government pick up the tab, or do local counties or agencies have to pay for it? What kind of support have you gotten from the U.S. EPA or other federal agencies?***

Meth lab clean-up in North Carolina is handled by the State Bureau of Investigation. The funds are allocated by the U.S. Department of Justice (Drug Enforcement Administration) which contracts with the Ferguson-Harbor Company to provide clean-up services in our state. If Rutherford County local government was required to pick up the tab, our local budget would be exhausted.

To date, we have received no support from the U.S. EPA or other federal agencies, excluding of course, the Department of Justice and Drug Enforcement Administration.

6. ***In your opinion, how well coordinated are the various federal grant and assistance programs which deal with meth enforcement (for example, Byrne, COPS, "Meth Hot Spots", OCDETF, RISS and HIDTA)? Does Congress need to provide a mechanism to better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with-ONDCP, the Justice Department, COPS, OCDETF, or DEA?***

Congress certainly needs to provide a central and stream-lined mechanism to better coordinate the funding available to fight methamphetamine abuse and addiction. The current system of providing federal grant assistance programs needs to be centralized under the Justice Department and the Drug Enforcement Administration. It currently takes a full time staff person to keep up with the available federal funding programs. Since you asked my opinion, I will certainly tell you that I strongly prefer dealing with the Department of Justice and the Drug Enforcement Administration.

7. ***What would the result be if court sentences were treatment based rather than jail time based? Would this legal approach be more effective at combating the meth addiction and "cooking" problem?***

Under no circumstances can treatment based or prison based sentences work independently of each other. If we are going to combat the methamphetamine epidemic, it will be necessary to have both jail sentences and treatment based sentences. In Rutherford County, we continue to arrest the same "meth cooks" two and three times prior to their prison sentencing. Mental Health experts have reported that meth is much more addictive than cocaine, heroin and marijuana. We must also weigh the danger that meth cooks have bestowed upon the communities of America. The chance of fire, explosion, water and air contamination, pose a great danger to our citizens. We must provide treatment for meth addicts, but we must also think of the multitude of dangers they are casting upon our local citizenry.

8. ***How much of a burden is it for your officers to report meth lab seizures to DEA's EPIC intelligence center? What could be done to make this reporting easier?***

Methamphetamine lab seizures in North Carolina are reported to EPIC by the State Bureau of Investigations. Centralization in reporting greatly reduces error and allows the local law enforcement community to concentrate on the criminal investigation.

Please know that the methamphetamine epidemic can not be successfully defeated without the work and cooperation of the local, state and federal governments. Agencies must continue to improve communications and continue working to protect the citizens of our nation. There is no easy answer to this problem. It must be addressed by law enforcement agencies as well as health care, social service and mental health care professionals. We will not let meth addiction destroy the lives and futures of our children while bankrupting our local, state and federal government. Thank you for your time and concern in addressing the methamphetamine epidemic.

SIDNEY L. GARDNER, M.P.A.
PRESIDENT

NANCY K YOUNG, Ph.D.
DIRECTOR

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DEBORAH WERNER, M.A.
DANIELLE NAVA, M.A.
LANI DALY
ASSOCIATES

August 31, 2005

Mark E. Souder, Chairman
Congress of the United States
House of Representatives
Committee on Government Reform
Subcommittee on Criminal Justice,
Drug Policy and Human Resources
2157 Rayburn House Office building
Washington, DC 20515-6143

Dear Chairman Souder,

Thank you for your invitation to testify at the Subcommittee's Hearing, "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies." I also want to extend my personal thank you for your dedication to solving the nation's drug problems and your long service to the country on these issues.

In follow-up to the hearing, the Subcommittee has posed four questions. This letter is my response to those questions. I should emphasize, however, that these comments are my own and do not reflect consultation with or the policies of either of the National Center on Substance Abuse and Child Welfare's (NCSACW) two Federal sponsoring agencies: the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Administration on Children and Families (ACF), Administration for Children, Youth and Families (ACYF), Children's Bureau, Office on Child Abuse and Neglect (OCAN).

1. From your role in the National Center on Substance Abuse and Child Welfare (NCSACW), how would you characterize the assistance that SAMHSA plays in facilitating your community outreach? Does SAMHSA just provide your center with funding, or does it also provide other services or assistance?

   As background to my response to this question, let me mention that the development and implementation of the NCSACW is through a contract with the SAMHSA, Center for Substance Abuse Treatment (CSAT) and is co-funded through an inter-governmental agreement between SAMHSA and ACFY, Children's Bureau (CB), Office on Child Abuse and Neglect (OCAN). As a contract rather than a grant-funding mechanism, all activities, tasks and expenditures are approved and carefully monitored by our CSAT and OCAN Federal Project Officers (FPOs). As contractors, we can make recommendations and suggestions to our FPOs on

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priorities, activities and tasks, but our contract is to implement the priorities and tasks determined by the Federal agencies as supervised by the FPOs.

As for assistance in facilitating our community outreach, both SAMHSA and ACYF provide access to other Federal staff and programs and involve us in many of their agencies' national meetings and activities. For example, we have access to materials developed by the agencies and linkages to other agency program staff to gather information, and we have used the agencies' listserv mechanisms to communicate with States and the agencies' grantees. We routinely participate as presenters and/or exhibitors at SAMHSA and CB conferences and meetings.

In addition to these Federal contacts and resources, Federal funding supports our subcontracts with a national network of organizations and professionals. In response to SAMHSA's Request for Applications (RFA), Children and Family Futures (CFF) developed a consortium of national organizations to develop and implement the NCSACW. The American Public Human Services Administration (APHSA), Child Welfare League of America (CWLA), National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Council of Juvenile and Family Court Judges (NCJFCJ) and National Indian Child Welfare Association (NICWA) are subcontractors to Children and Family Futures to assist in State and community outreach. The consortium organizations provide valuable, expert input to our staff on our activities and products and, importantly, communicate directly with their members about our activities, products and technical assistance. The consortium organizations represent more than 4,000 members from all across the nation.

2. If your center were to receive more Federal funding assistance, what would be the areas in which you would focus your spending?

   Our current activities encompass two broad areas: developing knowledge and providing technical assistance. In developing knowledge, we have produced and disseminated several monographs, white papers and resources for communities, including a white paper and resource list on parental methamphetamine use. However, more effort is definitely needed in this area.

   Additional Federal resources to address the methamphetamine crisis in child welfare could be used in at least four ways: (1) to gather experiential knowledge from communities who have been dealing with methamphetamine and disseminate their lessons learned to areas of the country that are now beginning to see the effects of the methamphetamine epidemic; (2) to expand the in-depth technical assistance (IDTA) program to create statewide, cross-system comprehensive plans to address the substance abuse, child welfare and family court issues; (3) to provide opportunities for cross-system partners from States and communities to come together to do information exchange, planning, and program development; and, (4) to fill information gaps. Each of these areas is discussed in more detail below.

   (1) *Gather and disseminate experiential knowledge.* There is a need to gather more in-depth information from States and communities that have longer-term experience working with parents with methamphetamine abuse and dependence

(e.g., Oregon, Washington State, Hawaii, Iowa, Idaho, Colorado, California) and disseminate their insights to others who are now struggling to respond to emerging methamphetamine problems in their communities. This effort would focus on the knowledge that these States and communities have gained about what works and what they would recommend to other communities. This information should be disseminated using multiple strategies, including distribution of monographs and other written products, presentations and workshops at conferences, and postings and announcements on our website. Reports and activities such as these generally take 9 to 12 months to complete and cost $75,000 to $100,000, depending on the number of sites that information is gathered from and whether in-person interviews are conducted.

(2) *Expand the In-Depth Technical Assistance (IDTA) Program.* A priority for technical assistance has been our IDTA program with States. This technical assistance is provided in a cross-system partnering approach, and it is the collaborative, cross-system nature of our funding, approach and solutions that makes NCSACW unique and effective. IDTA provides States with access to our knowledge, policy and practice tools and national networks through a part-time consultant assigned to each State. The consultant assists a State policy team to develop a State-wide plan to improve outcomes for children and their families affected by substance use disorders and child abuse or neglect. States make an investment in this work through devoting significant staff time to these activities. We have conducted two rounds of IDTA, we have had 14 States and 2 Tribes apply for assistance and have been able to serve 7 States and 1 Tribe.

In 2004/05 we worked with Colorado, Florida, Michigan and Virginia (those States were selected through a national solicitation to States). Their progress report and the products they developed are available on our website as examples for other sites (www.ncsacw.samhsa.gov). In 2005/06 we are working with Arkansas, Massachusetts, Minnesota and the Squaxin Island Tribe in the State of Washington. We are hoping that funding levels for 2006/07 will allow us to work with four additional sites. There is a concern, however, that currently projected budget reductions will limit our ability to reach that goal.

Additional Federal assistance would allow us to expand this program to additional States, conduct follow-up and on-going work with the first two rounds of sites, and extend the program to large cities and counties that administer their own child welfare and substance abuse services (e.g., Los Angeles County, New York City). The IDTA program requires approximately $75,000 per site for 15 months of services.

(3) *Facilitate Ongoing Networking and Information Exchange at the National, State and Local Levels.* Another priority is to provide better opportunities for sustained discussions between systems that work on these issues on the national, State, and local levels. Based on our more than ten years of experience in this area, we have found that the creative problem-solving needed to bridgethese sets of agencies is most effective when the agencies have ongoing contact and sustained discussions with each other.

Unfortunately, outside the few meetings we have been able to convene for the IDTA sites and our national conference in Baltimore in July 2004, there have been few Federally-sponsored meetings of this kind in the last five years. Regional meetings and wider inclusion of additional partners—notably maternal and child health, mental health and law enforcement, in the case of methamphetamine issues—would help spread the message about both challenges and solutions. We have conducted regional meetings of this type in California; costs for this type of 2-day meeting generally run approximately $1,000 per person for travel, room and board, speaker fees and materials. Additional funding would help provide this kind of meeting on a regional basis, with at least two meetings a year to keep participants actively involved.

(4) *Fill Information Gaps.* As evidenced in the hearing, there is a critical lack of the right kind of data on the methamphetamine and other substance abuse issues among families in child welfare. There is a need to work with Federal, State and local agencies to reduce the wide gap between the information we need and the data we have. This would include data analyses across the child welfare and substance abuse data sets, as has been accomplished in several counties. At present, there is no Federal requirement that child welfare agencies routinely collect data on the substance abuse issues facing families they serve. Similarly, there is no Federal requirement that substance abuse treatment agencies collect data on the children of parents who enter publicly-funded treatment. However, there are some States and communities that have bridged this information gap and could serve as examples of how to implement such data collection requirements. A brighter spotlight is needed on those examples of strong and inclusive information systems.

3. In your opinion, how well coordinated are the various Federal grant and assistance programs which deal with meth enforcement (for example, Byrne, COPS "Meth Hot Spots", OCDETF, RISS, and HIDTA)? Does Congress need to provide a mechanism to better coordinate those dollars? If so, which Federal agency or agencies are you most comfortable dealing with – ONDCP, the Justice Department, COPS, ODCETF, or DEA?

Federal coordination is always a challenge—as are similar efforts to coordinate at State and local levels. From our vantage point, Federal agencies working together in groups such as the Interagency Workgroup on Child Abuse and Neglect and prior coordinative attempts of ONDCP have been helpful. While we are not expert on justice-related enforcement activities, there does seem to be a clear need to better coordinate efforts across Federal agencies. For example, enforcement activities in regard to families with children may need better coordination with efforts of the Department of Health and Human Services to ensure that the prevention and treatment needs of family members are adequately addressed along a spectrum that fully includes interdiction, prevention and treatment.

The tools that seem to have helped State and local agencies coordinate best are (1) an annually updated and comprehensive inventory of programs (Arizona's is the best example, which has been in effect for twelve years and is now geo-coded to

specific sites); (2) ongoing summaries of which agencies' programs are most thoroughly evaluated, so that all agency partners have access to information about what works and can conform their programs accordingly; and, (3) a legislative or top administrative body that requires periodic reporting of progress and activities.

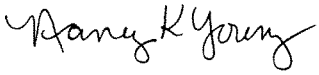
4. From your program's perspective, what legislative or programmatic changes would you recommend to better support victims of the meth epidemic?

   We would recommend the following:

   - Congress could require the development of specific prevention messages about methamphetamine and its effects, particularly directed to parents and to pregnant women;
   - Congress could act to improve treatment access for child welfare families so that those families receive priority for intervention and treatment services for both parents and children;
   - Congress could sponsor demonstrations and services research efforts to improve treatment and child welfare-related outcomes for families affected by methamphetamine and other substances;
   - Congress could increase training opportunities for child welfare workers to have better skills to work with children and families affected by substance abuse and methamphetamine issues as well as training for alcohol and drug prevention and treatment staff to work with families, particularly to address the safety, permanency and well-being of children;
   - Congress could ensure automatic acceptance of all prenatally-exposed children into Part C of the Individuals with Disabilities Education Act for children aged 0-2, and fund IDEA Part C services to meet the developmental needs of these children, whether or not they meet specific developmental delay criteria. This group of children should meet criteria for services based on their prenatal substance exposure rather than needing to demonstrate delays before they qualify for services. These developmental prevention services would enable their caregivers to access developmental interventions to prevent future developmental and educational deficits. This would need to go beyond the referral to IDEA programs required for substantiated cases under the Child Abuse Prevention and Treatment Act amendments of 2003.
   - Congress could provide resources and direction to improve our data systems to better monitor drug use among child welfare families and to appropriately monitor and provide services to children of parents who enter treatment.
   - The legislation introduced by Senator Snowe (S.614, The Family-based Treatment and Child Protection/Alcohol and Drug Partnership Act of 2005) is an excellent example of Federal bridge-building in a legislative proposal that has been offered, and we would encourage members of the Subcommittee to work with Senator Snowe on this legislation.

Thank you again for your leadership on this issue, please feel free to contact me if you need any further information or if our agency can be of help in the future.

Sincerely,



Nancy K. Young, Ph.D.
Director

WATAUGA COUNTY SHERIFF'S OFFICE
330 QUEEN STREET
BOONE, NORTH CAROLINA 28607

MARK SHOOK, SHERIFF

(828) 264-3761
FAX (828) 265-7617

August 4, 2005

Dear Chairman Souder,

I would again like to thank you for inviting me to speak before the Subcommittee on Criminal Justice as dealing with the Methamphetamine epidemic in our country. It was an experience that I will honor for the rest of my life. I will try my best to assist in any way that I can to rid the communities of our nation of this drug. I have seen all too often the devastation that it causes.

Answers to follow up questions.

1. The DEA pays for the clean up crew to come dispose of the toxic wastes. In our area, Ferguson Harbor stationed in Johnson City, TN is contracted to provide that service. I think the way to improve on this would be to have disposal companies in each state to cut down on the time that it takes for these crews to arrive on scene.

2. We have 6 officers including myself have received training from DEA to certify us in going into these labs on investigations. The training was paid for by the DEA. All of my Narcotics officers have gone through the DEA Basic Narcotics Investigations schools. The DEA here have really helped us with our training.

3. We have had training with the National Guard. I don't know how the closing of Fort Fisher is going to affect training because that is where most of there schools were being held. We have had the Meth. Lab recertification schools at the Fort Fisher location.

4. We do not have a drug court yet in our judicial district.

5. The DEA pays for the Meth Lab clean-ups through the COPS Program. We have not had dealings with the EPA on our labs. I know that our health department called the EPA on one of our lab seizures, but I don't know what the response was.

6. I feel that the monies pertaining to the Methamphetamine epidemic needs to be handled by just one Federal Agency instead of the many different ones. We have applied for several COPS grants and have not had success in getting any funds. Our Meth task force has attempted to get an OCDETF case open but have been denied. I have had a lot of support through the DEA and ATF with Federal prosecutions of some of our major Meth traffickers.

7. I have seen when these cooks are out of jail and free to roam, they resume cooking and the return to jail. I feel that the only way to get a lot of these people the treatment that they require is to have the treatment as part of their sentence in the DOC facility.

8. The North Carolina State Bureau of Investigations handles the reporting to the DEA. They have done a great job in handling this for the local departments.

I again appreciate the opportunity to testify before you and offer any assistance that I can give to help get this drug under control. I also applaud your concern in this problem and your willingness to do what it takes to help the citizens of our country.

Sincerely,

Mark Shook
Watauga County Sheriff

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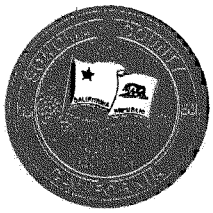
COUNTY CLERK



VALERIE BROWN
FIRST DISTRICT SUPERVISOR

vbrown@sonoma-county.org

September 15, 2005

Mark E. Souder, Chairman
Subcommittee on Criminal Justice,
Drug Policy and Human Resources
House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Re: "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies

Dear Chairman Souder,

Thank you very much for this opportunity to provide the requested further information to follow-up my testimony on July 26th on behalf of the National Association of Counties before the Subcommittee on Criminal Justice, Drug Policy and Human Resources of the House Government Reform Committee.

As you are well aware, methamphetamine abuse is a national crisis with county governments on the front-line dealing with the painful and costly consequence of meth abuse and production. I welcome the chance to provide information specific to Sonoma County, California.

Sincerely,

Valerie Brown

Valerie Brown
Supervisor, First District

Follow-Up Questions from Supervisor Valerie Brown
National Association of Counties

1. In your opinion, how well coordinated are the various federal grant and assistance programs which deal with meth enforcement (for example, Byrne, COPS "Meth Hot Spots," OCDETF, RISS, and HIDTA)? Does Congress need to provide a mechanism to Better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with – ONDCP, the Justice Department, COPS, OCDETF, or DEA?

The Sonoma County Sheriff's Department, the Sonoma County Probation Department, and the Sonoma County District Attorney's Office have been the recipients of funds from the Byrne program for approximately 16 years. The Byrne program has continually been supportive in its financial assistance to these departments in the war against methamphetamine. We believe the program has worked due to the constant support and availability by the State of California's Office of Emergency Services. Although all of the involved federal agencies and entities have been very helpful and cooperative, we feel that the best way to continue this well-coordinated program is to keep as much local and state input into decision making as possible. In terms of local methamphetamine enforcement, we have had excellent interactions with DEA and would recommend stronger funding considerations.

2. From your county's perspective, what legislative or programmatic changes would you recommend to better support victims or problems related to the meth epidemic?

In our opinion, to assist in the fight against the methamphetamine epidemic, a county-wide enforcement team, including departments such as Public Health, Child Welfare, District Attorney, County Fire (HAZ/MAT) and local Law Enforcement, targeting all aspects of the epidemic would be best. This team could include staff specialized in topics such as precursor chemical interdiction, drug endangered children, undercover buy programs, probation terms/court liaison officer, and methamphetamine interdiction on highways.

September 15, 2005

The Honorable Mark Souder
Chairman
House Government Reform Subcommittee on
Criminal Justice, Drug Policy and Human Resources
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Souder,

It was my pleasure to testify, on behalf of the National Association of Counties, at your July 26 hearing on methamphetamine abuse. Additionally, I am happy to respond to the additional questions for the record that you posed. Please find my answers below.

1. In your opinion, how well coordinated are the various federal grant and assistance programs which deal with meth enforcement (Byrne, COPS "Meth Hot Spots", OCDETF, RISS, and HIDTA)? Does Congress need to provide a mechanism to better coordinate those dollars? If so, which federal agency or agencies are you most comfortable dealing with – ONDCP, the Justice Department, COPS, OCDETF, or DEA?

Although NACo has not conducted any national studies on the quality of coordination of federal grant programs, such as OCDETF, RISS and HIDTA, we recommend the recently enacted Justice Assistance Grant Program (JAG) as a major "mechanism" for systematic coordination at the grassroots level. NACo strongly supports the JAG program and strongly urges the Congress to increase funding for it during the FY2006 appropriations process.

Under the JAG program, funds can be spent on:

- Law enforcement programs;
- Prosecution and court programs;
- Prevention and education programs;
- Corrections and community corrections programs;
- Drug Treatment programs
- Planning, evaluation and technology improvements.

The flexibility of the JAG program allows local governments to allocate funding where it is needed, within the criminal justice system. Furthermore, NACo believes that JAG could

be strengthened by requiring comprehensive planning as a condition for receiving funding. This would ensure that localities are making choices through a data-driven or evidence based process that would maximize federal funding. NACo would also suggest that a new title be added to JAG to encourage the creation of multi-jurisdictional programs in rural areas.

Additionally, NACo like to suggest that a high-level inter-agency and intergovernmental working group be established to improve coordination of federal, state and local resources in the fight against methamphetamine abuse. The mission of the taskforce would be to examine the impact of methamphetamine on society, re-evaluate the overall strategy to stem the spread of meth abuse and recommend any necessary improvements. The taskforce membership should be comprised of representatives from the law enforcement, public health, treatment, environmental sectors and policymakers from the local, state and federal levels.

2. From your county's perspective, what legislative or programmatic changes would you recommend to better support victims or problems related to the meth epidemic?

NACo is in support of a comprehensive and intergovernmental strategy to reduce methamphetamine abuse. Necessary components of this strategy must include prevention, education, treatment, law enforcement, child welfare, cleanup, public health, precursor control and research.

Limiting the sale of pseudoephedrine products would represent a major step forward in the fight against small toxic labs. This approach has proven successful in many states, including Oklahoma and Iowa. Senators Jim Talent and Dianne Feinstein have introduced the Combat Meth Act to replicate the successes of these states on a national scale. The Senate recently incorporated the Combat Meth Act into the FY2006 Commerce-Justice-Science appropriations bill. NACo urges the House to accept this provision during conference negotiations.

Additionally, NACo urges the Congress to enact the Methamphetamine Remediation Research Act of 2005 (HR 798). This legislation would establish voluntary guidelines for local governments and property owners to follow when remediating a former meth lab.

Furthermore, NACo would support an expansion of the Drug Endangered Children (DEC) program. This multi-disciplinary approach addresses the needs of the most innocent victims of methamphetamine abuse, the children of meth users. Under DEC, local law enforcement, prosecutors, medical professionals, child social service agencies and others work collaboratively to oversee the health and safety of children exposed to meth.

Prevention and education efforts are critically needed to raise the level of awareness with teens and young adults. NACo appreciates your efforts, along with Representative Rick Larsen, to increase the National Youth Anti-Drug Media Campaign by $25 million during consideration of the FY2006 Transportation, Treasury, HUD, Judiciary, District of

Columbia appropriations bill. We would like to work with you and Representative Larsen to ensure this funding is included in the final bill.

NACo, through our Methamphetamine Action Group, will be further developing our policy recommendations and conducting surveys on the various impacts of meth abuse. We would welcome the opportunity to share these with you at the appropriate time.

Thank you again for allowing me to testify on behalf of the National Association of Counties.

Sincerely,

Valerie Brown
Supervisor
Sonoma County, California

OCT 2 8 2005

Assistant Secretary for Legislative Affairs
U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

The Honorable Mark E. 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:

On behalf of Secretary Chertoff, thank you for your letter of October 5, 2005, concerning methamphetamines from the July 26, 2005 hearing "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies." As you are aware, the Department of Homeland Security did not participate in this hearing. The Department of Justice and the Office of National Drug Control Policy (ONDCP) were in attendance.

The Department of Homeland Security remains committed to fighting all illegal drugs entering the United States. The Department's Office of Counternarcotics Enforcement (CNE), along with Customs and Border Protection (CBP), U.S. Coast Guard (USCG), and Immigration Customs and Enforcement (ICE), are collectively working together to attack the production, manufacture, and transport of illicit drugs–including synthetics, such as methamphetamine. During FY 2004, DHS resources interdicted 1,367 pounds of methamphetamines at the U.S. border - that total increased to 1,388 pounds during FY 2005.

With the success that DHS has in interdicting Drug Trafficking Organizations (DTOs), I would like to briefly respond to your inquiry.

1. **Putting aside existing drug programs that have generated applications, what specific programs have been implemented by the U.S. Immigration and Customs Enforcement to target the meth problem?**

The Office of Counternarcotics Enforcement and Immigration and Customs Enforcement have been major contributors to the President's *National Synthetic Drugs Action Plan*—a roadmap for meeting the challenges posed by synthetic and pharmaceutical drugs. The Action Plan provides an overview of recent trends in the consumption and trafficking of methamphetamine, diverted pharmaceuticals, Ecstasy, and other synthetic drugs. This Plan also outlines a balanced approach focused on four core areas: prevention, treatment, regulation of chemicals and drugs, and law enforcement. As a result of the President's *National Synthetic Drugs Action Plan,* the Office of National Drug Control Policy's Synthetic Drug Interagency Working Group (SDIWG) was created. ICE and CNE are major contributors to this working group.

CNE and ICE also participate as full members of the International Drug Control Policy Coordinating Committee (IDC-PCC), chaired by ONDCP and the National Security Council. ICE is also providing significant input to the IDC-PCC's Southwest Border Strategy that is focused on developing a cohesive strategy to control the Southwest border and reduce the flow of drugs smuggled into the U.S. from Mexico, to include methamphetamine and methamphetamine precursors.

2. Precisely how much federal assistance under DHS's control has been allocated to such programs targeting meth since fiscal year 2001, broken down by fiscal year?

The Department of Homeland Security, specifically ICE, CNE, USCG, and CBP, has not received federal funding that is specifically programmed for the interdiction of methamphetamine.

3. What types of meth programs or efforts have been provided with federal assistance by DHS?

The Department of Homeland Security, specifically ICE, CNE, USCG, and CBP, has not received federal funding that is specifically programmed for the interdiction of methamphetamine, nor does DHS fund any programs or efforts that target domestic demand reduction. However, DHS fully supports the demand reduction concept and domestic efforts to combat methamphetamine usage.

4. What criteria have been utilized by DHS in determining the recipients of federal assistance and what types of performance measurement data reporting has been conditioned on the granting of such assistance?

DHS does not receive funding for allocation towards the domestic demand reduction of methamphetamine, nor does DHS fund any State and local law enforcement programs concerning methamphetamine enforcement. Therefore, DHS does not determine the recipients of federal assistance and does not set performance measures on this issue.

5. What has been the actual effectiveness of programs targeting meth that have received federal assistance from DHS?

DHS fully supports the need for demand reduction and domestic efforts to combat methamphetamine usage. However, ICE is tasked with investigating cases of narcotics smuggling that have a clearly articulable nexus to an international border. As such, ICE Special Agents will continue to diligently conduct narcotics investigations, including those involving the smuggling of methamphetamine and its precursors, as long as there is a nexus to an international border. CBP is tasked to protect all illegal commerce between the ports of entry and at the ports of entry. CBP is the first line of defense to interdict known illegal narcotics. As such, CBP will continue to enforce all illegal contraband from entering the United States.

I appreciate your interest in the Department of Homeland Security, and I look forward to working with you on homeland security issues. If I may be of assistance, please contact the Office of Legislative Affairs at (202) 205-4412.

Sincerely,

Pamela J. Turner
Assistant Secretary for Legislative Affairs

U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

February 10, 2006

The Honorable Mark Souder
Chairman
Subcommittee on Criminal Justice, Drug Policy,
and Human Resources
Committee on Government Reform
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Please find enclosed responses to questions directed to Joseph T. Rannazzisi, Deputy Chief of the Office of Enforcement Operations for the Drug Enforcement Administration, after his testimony at the Subcommittee's July 26, 2005 hearing entitled "Fighting Methamphetamine in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies."

The Office of Management and Budget has advised us that from the perspective of the Administration's program, there is no objection to submission of this letter. Please do not hesitate to call upon us if we may be of additional assistance.

Sincerely,

William E. Moschella
Assistant Attorney General

Enclosure

cc: The Honorable Elijah Cummings
Ranking Minority Member

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

"Fighting Meth in America's Heartland:
Assessing the Impact on Local Law Enforcement and Child Welfare Agencies"

July 26, 2005

Responses to Follow-up Questions for the Record

Joseph T. Rannazzisi
Deputy Chief
Office of Enforcement Operations
Drug Enforcement Administration

1. **Congress has appropriated $20 million a year for the DEA's Hazardous Waste Disposal program, which helps state and local agencies clean up meth lab sites. Apparently, DEA only spent $18 million of that money last year. Given the huge number of state and local agencies struggling to clean up meth lab sites, why hasn't DEA used up the entire $20 million? Do you believe that DEA is meeting all the demand out there?**

   In FY 2004, DEA received $19,789,549 from the Community Oriented Policing Services (COPS) Methamphetamine Enforcement and Cleanup program for the cleanup of clandestine methamphetamine laboratories seized by state and local law enforcement agencies. Of this amount, five percent, or $989,447, was set aside for program administrative costs, per a memorandum of understanding with COPS, leaving $18,800,102 available for hazardous waste clean-ups. In FY 2004, approximately $18,556,801 was expended for state and local cleanups (includes approximately $800,000 from DEA appropriated funds). The unobligated FY 2004 funds were carried over into the next fiscal year.

   In FY 2004, DEA cleaned up hazardous waste from approximately 9,800 clandestine methamphetamine laboratories seized by state and local law enforcement agencies, *i.e.*, every clandestine laboratory site for which we received a request from state and/or local authorities (including approximately 9,500 labs from COPS funds and approximately 300 from DEA appropriated funds). Since not all clandestine laboratories seized by state and local law enforcement agencies are reported to the national clandestine laboratory database, it is difficult to determine an accurate number of methamphetamine laboratories seized throughout the country by state and local law enforcement agencies. While it is not possible to provide a numerical measure of the effectiveness of the hazardous waste program, the DEA has made significant efforts to promote its Hazardous Waste Disposal program over the past several years (see DEA's response to question #2). Therefore it is unlikely that we have failed to satisfy the demand for our cleanup services.

We also note that a number of states received COPS "Hot Spots" earmark funding in FY 2004, which can be used for cleanups within a specified area. Additionally, the state of California funds the cleanup of the majority of clandestine methamphetamine laboratories seized by that states' law enforcement authorities.

A concern has been raised by some state and local law enforcement agencies regarding overtime paid by the agencies to officers waiting for the DEA hazardous waste contractor to arrive at the clandestine laboratory site. Depending upon the location, it could take several hours for the hazardous waste contractor to travel to the clandestine laboratory site. As such, some law enforcement agencies may choose to fund the cleanup rather than expend the officer overtime. In order to address this concern, DEA has begun to implement container pick-up programs which, in most cases, would enable officers with the requisite training in handling hazardous wastes to move the hazardous materials from the clandestine laboratory site to a secure container for pick up at a later date by the DEA hazardous waste contractor. The program is designed to ensure that hazardous waste is handled, stored and transported in accordance with applicable environmental legal requirements. A pilot study conducted in Kentucky was very successful and, as a result, the program will be expanded into a number of other states beginning in FY 2006.

2. **What efforts has DEA undertaken to publicize the Hazardous Waste Disposal program to state and local agencies? How does DEA contact them to let them know about the available funding?**

Since the program's inception, DEA has participated in numerous national conferences and meetings of organizations whose membership consists of state and local law enforcement officials, including the International Association of Chiefs of Police, the National Sheriffs' Association, the National Organization of Black Law Enforcement Executives, the Clandestine Laboratory Investigators Association, the National Methamphetamine Chemicals Initiative, the National Alliance for Drug Endangered Children, and several state-sponsored methamphetamine summits. The DEA Hazardous Waste Disposal program was actively promoted at these events.

The DEA has also published and distributed promotional material including over 100,000 copies of *A Quick Guide to the DEA Clandestine Laboratory Cleanup Program,* a tri-fold flyer that briefly describes what law enforcement personnel must know before, during and after seizing a clandestine drug laboratory utilizing the DEA hazardous waste disposal program. Additionally, the *Guidelines for the Cleanup of Clandestine Drug Laboratories* (also known as the "redbook"), co-authored by a Joint Federal Task Force which included representatives from the DEA, the Environmental Protection Agency, and the U.S. Coast Guard, has been widely distributed to state and local law enforcement and environmental agencies. (DEA is currently updating the guidelines, and anticipates publishing and distributing the revised edition in early FY 2006.)

In addition, since 1998, the DEA's Office of Training has provided clandestine laboratory training to more than 8,600 state and local officers and National Guard personnel. During this training the students are provided a copy of the redbook and instructed on how to access DEA's Hazardous Waste Disposal services. The Office of Training also provides this same training to new DEA special agents during basic training.

DEA Headquarters meets annually with the DEA Field Division Clandestine Laboratory Coordinators who work directly with state and local counterparts. The Clandestine Laboratory Coordinators act as liaisons between DEA and the state and local agencies, apprising them of hazardous waste disposal operational requirements, changes and improvements to the program, as well as availability of funding. The availability of DEA hazardous waste disposal services is well-known throughout the U.S. law enforcement community.

3. **How do state and local agencies apply for funding under the Hazardous Waste Disposal program? What percent of applications for funding are accepted, and how much can each agency get per application or per year?**

State and local agencies do not apply for funding under the Hazardous Waste Disposal Program. A state or local agency needs only to contact the DEA and request cleanup services. The DEA Hazardous Waste Disposal Section handles all financial aspects of the cleanup program including: contracting of hazardous waste disposal services, invoicing and payment for those services, and obtaining security clearances of contractor personnel. The state and local requests are handled on a "first come, first served" basis and there is no limit on the number of clandestine laboratory sites that the DEA will clean up. The only limit is the availability of funds. With the exception of a three month period in FY 2000, DEA has had sufficient funds to service all requests received.

4. **What kind of training is provided by DEA to state and local agencies to deal with meth lab investigation and clean-up? Is it specific to meth, or is it more general in scope?**

The DEA Office of Training's Clandestine Laboratory Training Unit offers three different courses for state and local officers.

During the 40 hour State and Local Certification program, students receive instruction in investigative techniques. Further, all students participate in actual methamphetamine synthesis at the DEA Laboratory under the supervision of a DEA Forensic Chemist. This instruction greatly enhances the students' ability to conduct investigations, and also enhances the students' expertise for court testimony and the submission of affidavits. The DEA also provides four and eight hour awareness blocks of instruction that do not achieve the certification level, but give students information needed to identify and take initial steps regarding methamphetamine labs. The DEA provides a one and one half hour block of training concerning meth lab cleanup, which includes instruction regarding agent/officer responsibilities at the scene, scope of contractor responsibilities, completion of forms, how to obtain COPS funding through DEA Clandestine Laboratory Coordinators, creation and submission of proper manifests listing all substances discovered in the lab, and the role of the site-safety officer as it pertains to contractor oversight. Other subjects covered during basic certification are toxicology, respiratory protection, protective equipment and clothing, decontamination, PH exercises (using PH test strips), assessment, practicals, raid planning, chemical and physical hazards, air monitoring, chemical/evidence handling, Air Purifying Respirator fit-test, and extensive practical exercises. At the completion of training, students are "safety-certified" by Occupational Safety and Health Administration (OSHA) standards. The Clandestine Laboratory Training Unit also conducts a Site-Safety Officer school for state

and local officers. OSHA regulations require that at each clandestine drug laboratory site one person must act as a Site-Safety Officer. The Site-Safety Officer is responsible for the safety of the entire laboratory site and for coordinating with non-law enforcement agencies such as the fire department and child protective services. Upon completion of the course, students are qualified to serve as the Site-Safety Officers at a clandestine drug laboratory.

The third course offered by the Clandestine Laboratory Training Unit is a Tactical School, during which students who have previously graduated from the State and Local Certification program return to Quantico for 40 hours to specifically address tactical issues. This course is practical in nature, with little classroom time. Students use tactical equipment in a practical environment to address the issues unique to the contaminated environment of a methamphetamine lab.

The training provided by DEA's Clandestine Laboratory Training Unit focuses primarily on methamphetamine. Other types of laboratories such as PCP (phencyclidine) and MDMA (also known as "ecstasy") are briefly mentioned. In FY 2004, approximately 95% of all labs seized in the United States were producing methamphetamine.

5. **How do state and local agencies go about applying for training? How many agencies apply, and how many is DEA able to help per year?**

Within each DEA Field Division, in addition to the Clandestine Laboratory Coordinator, there is a Division Training Coordinator. Training requests by agency or individual are directed to the Clandestine Laboratory Coordinator or the Division Training Coordinator within the Division. The Clandestine Laboratory Coordinator maintains a list of those who have requested training.

The Clandestine Laboratory Training Unit located in Quantico, Virginia, reviews the clandestine laboratory seizure statistics compiled through the National Clandestine Laboratory Seizure System. After reviewing the lab seizure data for each state, the Clandestine Laboratory Training Unit assigns class slots to the Division Clandestine Laboratory Coordinators in proportion with the lab seizure statistics. As the training slots become available, the Clandestine Laboratory Coordinators will notify and assign class dates to those individuals on the waiting list. In this manner the DEA representative closest to the problem makes the decision as to who attends the classes. The Clandestine Laboratory Training Unit does not routinely assign individuals to the classes.

Since many requests for training are made informally, it is difficult to determine how many agencies actually "apply." Telephone calls and casual requests in the course of normal duties are more common than written petitions. Most requests for training are directed at Divisional level to the Division Training Coordinator or the Clandestine Laboratory Coordinator, though when a training request is sent directly to the Clandestine Laboratory Training Unit it is re-routed to the respective Field Division. Records are kept for individuals who attend training, and the state they are from. The Clandestine Laboratory Training Unit has not maintained records by agency (either requesting or attending).

6. How were your drug-endangered children guidelines developed? Who was consulted? Did you consult with child welfare service professionals?

The DEA's guidelines for drug-endangered children were developed through consultations and assistance provided by professionals such as pediatricians, EMS personnel and other medical personnel, child protective service professionals, child advocacy centers, national and state child abuse prevention organizations and foster care agencies. Additionally, information was used from research conducted by the National Jewish Hospital, Vanderbilt Burn Center, Joseph M. Still Burn Center and other medical facilities, as well as the Department of Health & Human Services, Administration for Children and Families, and the Department of Justice, Office for Victims of Crime, and from the Attorney General's Guidelines for Victim Witness Assistance.

A significant resource for information and assistance has been the National Alliance for Drug Endangered Children (National DEC Alliance). The DEA works closely with the National DEC Alliance as well as the 20 state alliances. The National DEC Alliance is a partnership of individuals from law enforcement, child protective services, medical and research professionals, prosecutors, and other organizations that work to provide a multi-disciplinary response to drug endangered children. The National DEC Alliance Medical and Research working group developed a national medical evaluation protocol that is made available through the DEA website, under Resources for Victims. In addition to DEA literature and resources, National DEC Alliance resources are made available at national, state and local conferences as well as federal, state and local law enforcement agencies.

In addition, the Victim Witness Program Manager (VWAP) incorporates training and awareness received on Child Abuse and Neglect from the American Prosecutor's Research Institute and other related instruction. Methamphetamine and clandestine laboratory reference material is obtained from various DEA clandestine lab certified personnel from across the country, the Clandestine Lab Training Unit in Quantico, Virginia, and the National Methamphetamine Chemical Initiative, and is incorporated into the VWAP and DEC literature. In turn, the DEA VWAP provides DEC instruction at the Clandestine Lab Training facility for federal, state and local law enforcement.

U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

February 14, 2006

The Honorable Mark E. Souder
Chairman
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Committee on Government Reform
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This responds to the questions for the record directed to Laura J. Birkmeyer, Chair of the National Alliance for Drug Endangered Children, Director of the National Methamphetamine Chemicals Initiative, and Executive Assistant United States Attorney for the Southern District of California, following Ms. Birkmeyer's testimony at the Subcommittee's July 26, 2005 hearing entitled, "Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies."

Thank you for the opportunity to supplement Ms. Birkmeyer's testimony. The Office of Management and Budget has advised that there is no objection to the presentation of these responses from the standpoint of the Administration's program. If we may be of additional assistance, please do not hesitate to contact this office.

Sincerely,

William E. Moschella
Assistant Attorney General

Enclosure

cc: The Honorable Elijah E. Cummings
Ranking Minority Member

Responses to Follow-Up Questions from July 26, 2005, Testimony of Laura J. Birkmeyer before Subcommittee on Criminal Justice, Drug Policy, and Human Resources - Committee on Government Reform

1. The National Alliance for Drug Endangered Children receives funding through grants and other forms of support from U.S. Department of Justice- Community Oriented Policing Services (COPS), U.S. Department of Justice- Office for Victims of Crime, the Drug Enforcement Administration, and the Office of National Drug Control Policy. How are the proposed changes to the President's fiscal year 2006 budget going to impact your program?

First, we think it important to clarify that the National Alliance for Drug Endangered Children has not received any monies from the Department's Office of Victims of Crime, the Drug Enforcement Administration or the Office of National Drug Control Policy. We do not expect that the President's FY 2006 budget will have a meaningful impact on the National Alliance.

Certainly the National Alliance is free to apply for any appropriate competitive grant program that may be available to it from the Office of Justice Programs in FY 2006. The National Alliance must be distinguished from the National DEC Training Program, which is directly funded by two sources and supported by others.

The National Alliance is presently neither a government entity nor a non-profit. Formed in the fall of 2003, it is an association of individuals from various states who have organized to promote the concept of assisting drug endangered children and to provide information to those communities and states wishing to form drug endangered children teams. With one exception, the National Alliance has received no money (grant or otherwise) directly from any source. In FY 2004, the COPS program provided a grant of $100,000 (from discretionary methamphetamine funding) for the purpose of enabling the National Alliance to hold an inaugural National Drug Endangered Children's conference and bring together professionals from all states which had DEC programs. Grant funds remaining from that conference were carried over so that a second national conference could be held. The second conference was held October 3-5 in Washington, D.C. COPS also pledged to provide an additional $28,000 of FY 2005 funds (through another source) to support the 2005 conference.

The National DEC Training Program, on the other hand, received a $400,000 grant (from discretionary methamphetamine funding) from COPS, which is its primary funding source. This grant is used to fund the travel of instructors, develop curriculum and provide training materials cost-free to requesting states. The COPS funding will be depleted in FY 2006. The

National DEC Training program also received a three year grant from the Department of Justice - Office for Victims of Crime ("OVC") to pay the salary and minor expenses for the National DEC Training Coordinator. That grant will expire in August 2006.

We also note that the Chair of the National Alliance also serves as the Director of the National Methamphetamine Chemicals Initiative ("NMCI"), which is HIDTA-funded. The NMCI has as one of its goals the promotion of the DEC concept and strongly encourages all its law enforcement members to participate in DEC programs.

2. From the Drug Endangered Children perspective, what legislative or programmatic changes would you recommend to better support victims of the meth epidemic?

At this time, the federal laws in place are sufficient to identify drug endangered children as crime victims. The National Alliance for Drug Endangered Children would be pleased to work with Congress to develop a comprehensive list of programmatic recommendations for the multiple agencies that have or may be able to assist drug endangered children. We endorse an approach that addresses the problem of drug endangered children with multi-disciplinary responses so that child victims receive integrated and long-term support.

3. Communities in more than a dozen states have formed DEC Alliances dedicated to rescuing, defending, sheltering and supporting drug endangered children. Are there plans for the National Alliance to expand to all states?

One goal of the National Alliance is the formation of statewide or regional DEC Alliances in all states that have drug endangered children. The National Alliance serves the state alliances by providing technical support and information and hosting an annual national conference addressing issues which have an impact on multiple systems serving drug endangered children. The Alliance has also formed working groups of nationally recognized experts to ensure that accurate and helpful information is provided to DEC Alliances and the public. We encourage collaboration among the various governmental, medical, scientific and research entities addressing drug endangered children issues. As more states receive training about the needs of drug endangered children and the use of multidisciplinary teams to assist them, it is anticipated they will form DEC Alliances. We believe the National Alliance can best support and assist DEC programs throughout the nation by creating a National DEC Resource Center and we have outlined a plan to develop such a center and provide web-based information to as broad an audience as possible.

4. Approximately what percent of drug cases prosecuted by the San Diego U.S. Attorney's Office are meth-related? Has that grown or shrunk over the recent past?

For Calendar Year 2004, approximately 12% of the drug cases prosecuted by the U.S. Attorney's Office for the Southern District of California were for crimes in which methamphetamine was the controlled substance charged. In CY 2001, the percentage was 7.1%; in CY 2002, the percentage was 10.7%; and in CY 2003, the percentage was 12.5%. Based on data currently available, the percentage from January through mid-August 2005 is 16.2%. It should be noted that these statistics do not include the number of cases involving the importation, distribution, or possession with intent to distribute (or other related crimes) of chemicals used to manufacture methamphetamine, including but not limited to pseudoephedrine, iodine, red phosphorus and hyposphosphorus acid.

5. Have you seen any significant shifts or trends in the meth-related cases prosecuted by your office? Are you seeing more cases of meth smuggling across the border?

With respect to the Southern District of California, we have seen no large-scale methamphetamine lab cases in our district in the last few years. However, we have seen an increase in the number of organized efforts to smuggle essential chemicals (such as iodine, red phosphorus and hypophosphorus acid) from Mexico to the U.S. through the ports of entry for further distribution to points north and for ultimate distribution throughout and outside of California. There is a significant amount of methamphetamine being smuggled from Mexico through our district by some of the same organizations that smuggle other contraband and it is not uncommon for methamphetamine to be one of the controlled substances recovered in polydrug loads. In terms of raw numbers, we have not seen a large increase in the number of methamphetamine seizures at the Southern District ports of entry, although there appears to be an increase in the amount of methamphetamine per load seized.

Based on information provided by the El Paso Intelligence Center, the Department of Homeland Security and other sources, we are aware that the total number of methamphetamine seizures at ports of entry along the Southwest Border has significantly increased over the last few years, with sharp increases at the Arizona and Texas ports of entry.

The Oregonian

The Mexican Connection

Sunday, June 05, 2005

STEVE SUO
The Oregonian

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

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

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

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

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

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

Mexican authorities have moved to restrict the number of cold pills consumers can buy, to confine sales to pharmacies and to shut down a number of distributors. But only this year is Mexico beginning to roll back the amount of pseudoephedrine that companies can import.

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

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

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

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

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

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

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

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

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

New volume in U.S.

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

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

"We had bad problems with the mom-and-pop labs, but 50 mom-and-pop labs aren't half of one of these shipments we're seeing here," said David Nahmias, U.S. attorney for the Northern District of Georgia. The Mexican cartels will replace the meth supplied by local labs, Nahmias predicted, "with double the volume, double the purity, double the quality."

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

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

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

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

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

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

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

Mexican officials say the country's consumers are demanding more cold medicine as their economy grows.

Jose Luis Santiago Vasconcelos, Mexico's top drug prosecutor, said the cartels are obtaining only small amounts of pseudoephedrine from the domestic pharmaceuticals industry. "The legal market is not the main source," he said.

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

A vulnerable portal

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

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

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

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

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

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

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

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

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

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

Maria del Rocio Alpuche, a manager at Sica, declined to discuss the theft, Vasconcelos' investigation or the company's patterns of imports. She said Sica's customers "all know us, since we have 40 years in the market in Mexico."

Six companies accounted for 90 percent of Mexico's pseudoephedrine imports in 2004, which came mainly from India, China and Germany. Most of those importers also declined interview requests.

The Mexican subsidiary of BASF, which imports pseudoephedrine from its factory in Germany and sells it to drug companies, said it was impossible any of its product had landed in illegal channels because it is closely regulated.

Asked why BASF's sales in Mexico grew from 10 tons in 2002 to 52 tons in 2004, spokesman John Schmidt said only the company's customers would know the answer. "It sounds to me like you're trying to put the onus on BASF," Schmidt said.

Vanishing pills

The risk of diversion rises after Mexican pharmaceutical companies turn the pseudoephedrine powder into pills. Sometimes, the cartels buy large quantities of cold medicine from dishonest pharmacies. Other times, they use front companies to buy pills from drug wholesalers.

Mexican authorities said they learned in 2004 that the Mayo Zambada/Chapo Guzman organization, an emerging leader in Mexican meth production, had enlisted a major pharmaceutical wholesaler in Guadalajara.

"What did we find with this distributor?" Vasconcelos said. "That one of its managers was selling large quantities of pseudoephedrine to pharmacies that didn't exist or to pharmacies that did not have the authorization of the secretary of health to sell that type of controlled medicines."

Pharmacies pose an even bigger problem, he said. The government has "constant surveillance over the distributors," Vasconcelos said. "Where it gets more difficult is with the pharmacies on the street, because there you can't have control. They can say they sold 50 cases when they only sold five cases, and the other ones were diverted."

Farmacias Similares, a leading pharmacy chain in Mexico, has rejected a number of suspicious orders. Spokesman Vicente Monroy said a supposed wholesaler last year requested a large load of cold pills containing pseudoephedrine, anti-diarrhea formulas and other medications. The other medicines could wait, the wholesaler said, but he needed the cold pills immediately.

Authorities have confiscated millions of Mexican-made pseudoephedrine pills from airports, buses and meth labs in Mexico.

Victor Clark Alfaro, a Tijuana human-rights advocate who has interviewed numerous meth cooks, said pseudoephedrine pills are readily obtained in the border city. "They always tell me, 'Victor, it's very easy. You can buy from this woman 10,000 boxes,' " Clark said.

Traffickers use sophisticated metallic presses to remove the pills from foil blister packs. The pills are dipped in a solvent to remove inactive ingredients and then transformed into meth.

At least 16 of the roughly 50 pseudoephedrine brands made in Mexico have turned up in the hands of suspected drug traffickers since 2000, reports from Mexican military and police agencies show.

Cold pills made by Productos Farmaceuticos Collins are among the most frequently seized. In March, Mexican police stopped a shipment of 200,000 of the company's Lovarin P cold pills at a delivery service in Mazatlan, one of at least 15 seizures involving Collins' products over the past five years.

The company's imports of pseudoephedrine have risen almost sixfold since 2000, from 3 tons to 17, customs records show. Collins officials did not respond to written questions and telephone calls seeking comment.

A spokesman for Schering-Plough's subsidiary in Mexico, the country's leading seller of pseudoephedrine products, said the company is "extremely concerned" that its Afrinex pills have been confiscated frequently by narcotics officials.

Assistant General Manger Sergio Ulloa said Schering-Plough S.A. de C.V. cooperates with the authorities in every investigation, sells only to well-established distributors and turns away business when it has doubts. The company delivers its product directly to the distributor's warehouse. What happens after that, Ulloa said, is "something that is out of our control."

Dire consequences

Mexico's pseudoephedrine surplus is fueling a rise in the availability of Mexican meth in new U.S. markets -- a connection illustrated vividly in October, when U.S. investigators linked a meth lab outside Mexico City to a group of traffickers in Atlanta.

Mexican prosecutors said federal police found the lab after arresting three men in a pickup hauling a load of Schering-Plough's Afrinex pills. At the lab was a vehicle with a hidden compartment containing 22 pounds of finished meth, enough for about 100,000 hits. Its destination, Mexican officials said, was points north.

Atlanta is now awash in Mexican-made meth, according to U.S. law enforcement officials. As recently as 2003, federal agents were seizing shipments of 4 to 7 pounds of meth at a time. Last year, it was 20 to 70 pounds.

In January, DEA agents intercepted 125 pounds headed to Atlanta from the border town of Brownsville, Texas. Then, in March, they nabbed 174 pounds. It was one of the largest seizures in U.S. history.

Sherri Strange, special agent in charge of the DEA in Atlanta, said Mexico's Gulf and Armando Valencia cartels are battling for turf in Atlanta. The city has become a command center for distributing the drug from Miami to New York, according to federal law enforcement officials.

"I'm more concerned about this drug than any drug issue in the district or the state," said Nahmias, the federal prosecutor in Atlanta. "We've had this rising tide. Now it's like a tidal wave, and it's about to crash down on us because of the huge amounts we're seeing."

Users are flocking to the Mexican product, frequently referred to as "ice." Georgia's treatment admissions for meth, a leading indicator of the number of users, quadrupled between 2000 and 2003.

Assistant U.S. Attorney Robert McBurney said some Georgia users now ask for meth by the name of their favorite Mexican supplier.

"There's no comparison" with homemade meth, McBurney said. "The stuff that's made in Mexico is a lot better."

Low on the agenda

Mexican drug traffickers have cranked up production of meth unimpeded because Mexico's soaring imports of pseudoephedrine make the chemical easy to obtain. Yet documents, interviews and public testimony show that the growth in imports has caused little stir among top U.S. policymakers.

The topic receives no mention in the DEA's latest unclassified intelligence report on Mexico, published in November 2003; the National Synthetic Drugs Action Plan, published in October; or the U.S. State Department's International Narcotics Strategy Report, published in March.

Robert Charles, chief U.S. diplomat on narcotics issues from October 2003 until March 2005, said he was never alerted to the problem.

"That's a dramatic uptick," Charles said in April, when told by The Oregonian that Mexico's pseudoephedrine imports had grown from 95 tons in 2002 to 224 tons in 2004. Charles said that if he had seen those numbers while in office, he would have raised questions directly with Mexico's attorney general and senior U.S. officials.

U.S. Attorney General Alberto Gonzales was briefed on the pseudoephedrine imports in April, before meeting with Mexico's attorney general. During a Senate hearing in May, U.S. Sen. Patty Murray, D-Wash., asked Gonzales what the United States was doing to smash the cartels' supply of pseudoephedrine.

Gonzales said that U.S. officials were working with law enforcement in other countries. "And I think we're making some progress," he said. "Obviously, more needs to be done."

Gonzales did not mention the fact that Mexico's legal imports of pseudoephedrine have soared over the past five years.

DEA Administrator Karen Tandy also did not address Mexico's legal pseudoephedrine imports when she was asked about Mexican meth production during congressional testimony in March.

Tandy and other U.S. officials instead have highlighted a smaller source of pseudoephedrine in Mexico: Hong Kong.

DEA officials say drug companies in Hong Kong have illicitly shipped 450 million cold pills to Mexican traffickers since 2003 -- enough to yield 13.5 tons of pseudoephedrine a year. By comparison, The Oregonian's analysis suggests traffickers obtained 95 to 132 tons from products made by Mexico's own pharmaceutical industry.

Mid-level U.S. officials say they are aware of the growth in Mexico's legal imports of pseudoephedrine, which began in 1998, and have been discussing it with their Mexican counterparts.

"We talk to them very frankly about any suspicions we have," said Collier, the DEA's chief of dangerous drugs and chemicals. "I think movement by them on this issue indicates that they do understand and are taking steps, at any rate, to try and at least prevent diversion from the legitimate marketplace."

Diana Page, a U.S. Embassy spokeswoman, said it was the Mexican government that contacted U.S. officials about the country's massive influx of pseudoephedrine. She said Mexican health officials asked for help creating a computer registry of imports and domestic sales, telling U.S. officials, "We know we have a problem."

Charles, the former assistant secretary of state for international narcotics and law enforcement affairs, said the problem has not risen higher on the U.S. agenda with Mexico because of competing concerns such as corruption, immigration and trade. The list is so long, he said, that "no one issue seems to be ever able to fully dominate the discussion."

"More pressure has to be applied to Mexico than has been applied," Charles said. "But you're talking to the guy who believes that the most, versus a trade guy, who would say to you, 'Now, now, now, that's not the No. 1 priority.' "

A moving target

Even if the Mexican government succeeds in clamping down on pseudoephedrine, there is little to prevent traffickers from leapfrogging to other countries for their essential meth ingredient. For more than a decade, the traffickers have done just that, rebounding from each new restriction on meth ingredients by finding sources that U.S. authorities ignored.

Mexico's Amezcua brothers pioneered mass production of the drug in the early 1990s by ordering ephedrine powder direct from manufacturing nations: India, China, Germany and the Czech Republic. When those countries cracked down in 1995, Mexican cartels began buying pseudoephedrine pills in the United States. U.S. officials tightened their rules in 1997, and traffickers turned to Canada, which lacked any restrictions.

Canadian companies began importing dramatically more pseudoephedrine powder, much of which DEA officials say was converted to pills and sold to cross-border smugglers. U.S. officials responded vocally, repeatedly flagging Canada's rising imports in State Department narcotics reports. President Bush and congressional leaders leaned on Canada to act.

What U.S. officials failed to note, at least publicly, was that Mexico's pseudoephedrine imports were also growing. United Nations trade statistics show Mexico's imports of pseudoephedrine matched Canada's increase roughly ton for ton starting in 1998, the year DEA officials pegged as the start of the Canadian boom.

By 2002, a joint report by the DEA, State Department, Central Intelligence Agency, White House drug czar and other agencies theorized what would happen when the Canadian pipeline closed. Mexican traffickers would move production to Mexico, the report said, "where chemicals could be more easily obtained."

DEA agents and the Royal Canadian Mounted Police eventually snared hundreds of smugglers, and

Canadian officials enacted new regulations on pseudoephedrine in 2003. The flow of pills from Canada to the United States dried up, while Mexico's imports kept rising.

Facing a shortage of Canadian pseudoephedrine, Mexican traffickers dramatically scaled back production in California. The number of superlabs found in the United States fell from 244 in 2001 to 53 in 2004. U.S. officials say the labs simply moved to Mexico. As a result, shipments of finished meth found moving across the U.S. border grew from 2,600 pounds in 2002 to 4,500 pounds in 2004.

U.S. officials expect other countries to become targets for the cartels as Mexico tightens its controls.

If that happens, the agency most likely to spot the trend would be the Vienna-based International Narcotics Control Board, which tracks imports and exports of drug chemicals globally. The board's three chemical investigators, sifting through export documents, succeed in halting hundreds of suspicious orders annually.

But the board's power, like its staffing, is limited. With narcotic drugs such as codeine, the agency publishes limits on how much each country should import based on an estimate of medical need. If countries exceed those limits, the board can announce they are violating international law. It has no such authority over pseudoephedrine.

Some U.S. lawmakers and administration officials say it is time for the United States to become more directly involved, in Mexico and beyond.

U.S. Rep. Darlene Hooley, D-Ore., has introduced a bill that would allow DEA officials to inspect sales records of all foreign manufacturers of ephedrine and pseudoephedrine. Companies that refuse would lose the ability to export to the United States. That would enable the DEA to quickly detect a spike in shipments anywhere in the world.

Nick Coleman, counsel to the House Government Reform subcommittee on drug policy, said U.S. officials must work with other countries to scrutinize more intently the flow of pseudoephedrine for legitimate use.

"It's not clear internationally that we are able to track these things," Coleman said, "because at some point, they drop off the radar."

Steve Suo reported this story in Mexico City and Vienna. Freelance journalist Adrienne Bard contributed to this report in Mexico. Steve Suo: 503-221-8288; stevesuo@news.oregonian.com

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The Oregonian

Mexico's math problem adds up to a U.S. meth problem

The gap between Mexico's legal uses of cold pills and its swelling imports of pseudoephedrine points to diversions for meth

Sunday, June 05, 2005

STEVE SUO
The Oregonian

Mexican law enforcement officials have worked with U.S. drug agents since 2003 to end the smuggling of pseudoephedrine pills from Hong Kong, believing it to be the largest source of the cold medicine used by methamphetamine traffickers.

However, an analysis by The Oregonian shows that Hong Kong is only a secondary supply of pseudoephedrine for the Mexican drug cartels fueling the U.S. meth trade. The dominant source: cold medicine manufactured by Mexico's legitimate pharmaceutical industry.

The newspaper reached this conclusion by estimating Mexico's legitimate demand for pseudoephedrine, something that U.S. officials have never done and that Mexican officials are only now attempting. The analysis showed that legitimate demand is much smaller than the 224 tons that Mexico imported last year.

Only 81 tons of pseudoephedrine was required to make roughly 140 leading cold medicines in Mexico last year, the newspaper found. This figure was based on sales at 28 major wholesalers and pharmacy chains reported by IMS Health, a U.S.-based market research firm. The newspaper determined the dosage of pseudoephedrine in each product, then multiplied that amount by the number of pills or milliliters of liquid sold.

Even this estimate is generous because the IMS data may inadvertently include illegitimate sales.

Separately, sales data provided by Farmacias Similares, a huge discount pharmacy chain not included in the IMS survey, accounted for another 10 tons of pseudoephedrine.

Solid statistics on cold medicine use by Mexico's extensive public health system were unavailable. The best available data indicate that Mexico's main federal provider of health services consumed, at most, about 16 tons.

Roughly 6 tons was assumed wasted during manufacturing, based on industry standards.

An additional 15 tons went to U.S.-owned "maquiladora" factories that manufacture cold medicine for the U.S. market, according to Mexico's health ministry.

The ministry said about 1 ton was exported to other countries.

In total, these legitimate uses of pseudoephedrine accounted for 129 tons, or 95 tons less than what the country imported. And this estimate may understate the problem.

Using a different approach, The Oregonian attempted to answer what a plausible growth rate for Mexican pseudoephedrine imports might be.

From 1996 to 1998, just before Mexico's pseudoephedrine boom began, its imports of the chemical averaged 30 tons a year. The newspaper assumed these were entirely legitimate, then factored in the effects of population growth, rising standards of living and a ban on another popular decongestant, phenylpropanolamine.

Calculated this way, legitimate uses should have grown to 92 tons by 2004. That would leave 132 tons available for the meth trade.

An assessment by Mexico's health officials suggests the amount diverted could be even more. They have told international authorities the country could need as little as 70 tons of pseudoephedrine, an estimate that is still being refined.

Mexico's pseudoephedrine surplus of roughly 100 tons matches what meth cooks in Mexico require each year. Previous analysis by the U.S. Drug Enforcement Administration shows that roughly 200 tons is needed to produce all the meth sold in the United States, and DEA Administrator Karen Tandy told Congress in March that labs in Mexico make about 53 percent of U.S. meth supply.

Jose Luis Santiago Vasconcelos, Mexico's deputy attorney general for organized crime, acknowledged in an interview that drug cartels are obtaining pseudoephedrine pills made by the country's pharmaceutical industry.

However, Vasconcelos said pills made in Hong Kong are the cartels' main source. U.S. officials say shipping records and other intelligence show Hong Kong pharmaceutical manufacturers have shipped 450 million pseudoephedrine pills to Mexican front companies since 2003. On April 1, Hong Kong authorities agreed to verify each Mexican importer's credentials.

At the standard size of 60 milligrams, the Hong Kong pills would yield only 13.5 tons of pseudoephedrine a year.

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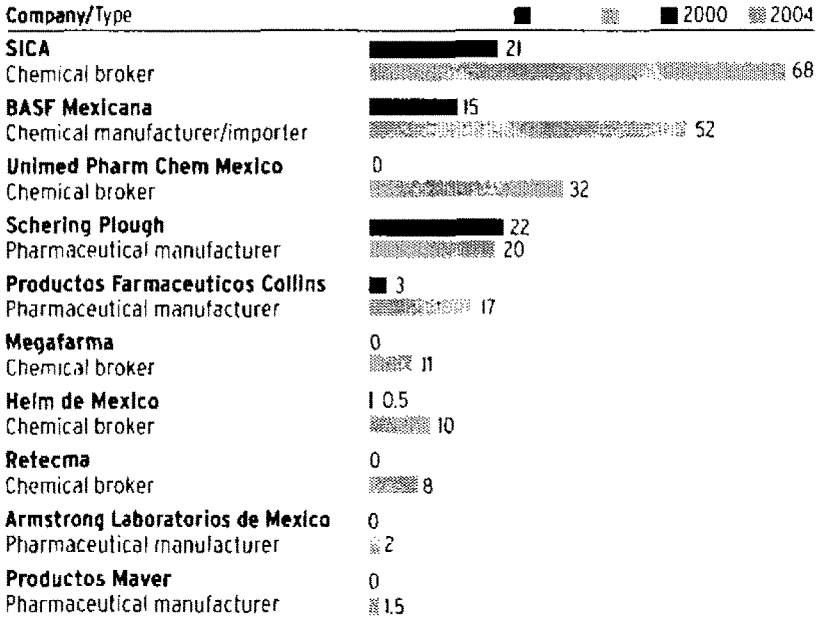
TOP 10 PSEUDOEPHEDRINE IMPORTERS, 2004

Here are imports, in tons, by company.

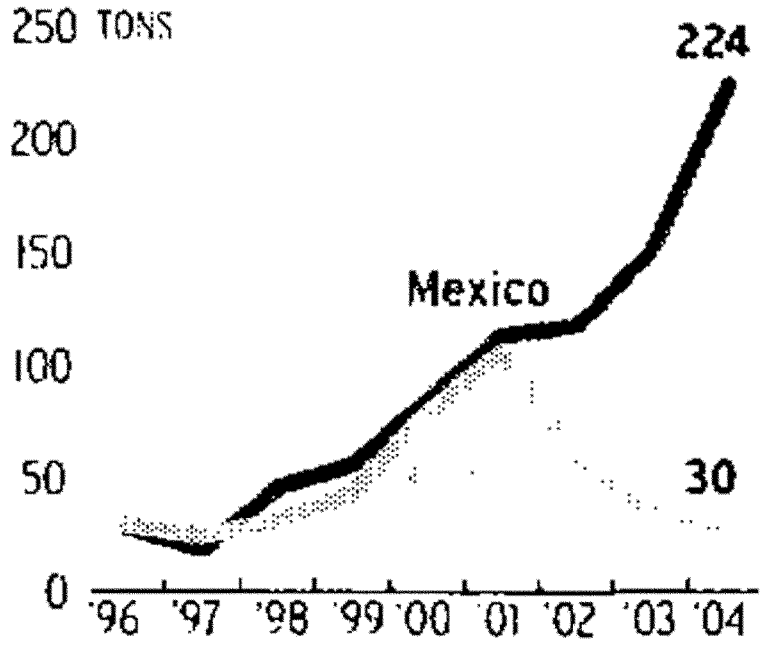


Source: Mexican customs data via Mexico's National Chamber of the Manufacturing Industry (CANACINTRA)

MICHAEL MODE/THE OREGONIAN

PSEUDOEPHEDRINE IMPORTS

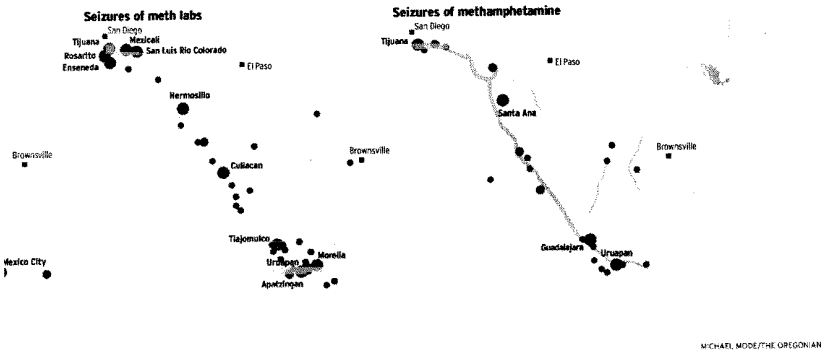
The following are data on pseudoephedrine imports that Canada and Mexico reported to the United Nations.



Source: United Nations Statistics Division and Mexican customs data

Pseudoephedrine imports (TONS)

Exporter	2000	2004
India	23	72
China	5	69
Germany	18	61


Seizures of meth labs
San Diego
Tijuana
Mexicali
Rosarito
San Luis Rio Colorado
Ensenada
El Paso
Hermosillo
Brownsville
Culiacan
Brownsville
Tlajomulco
Morelia
Uruapan
Apatzingan
Mexico City
Seizures of methamphetamine
San Diego
Tijuana
El Paso
Santa Ana
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