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

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

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

STATEMENT OF
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EXECUTIVE OFFICE OF THE PRESIDENT

before the

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

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

JULY 24, 2012

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Methamphetamine Availability and Production

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[12] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=23

[13] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=68

[14] Bureau of International Narcotics and Law Enforcement Affairs. *2012 International Narcotics Strategy Report*. U.S. Department of State. [March 2012]. Available: http://www.state.gov/documents/organization/187109.pdf#page=68

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

[16] National Seizure System, El Paso Intelligence Center.

[17] National Seizure System, El Paso Intelligence Center.

[18] National Seizure System, El Paso Intelligence Center.

[19] National Seizure System, El Paso Intelligence Center.

[20] National Drug Intelligence Center (NDIC). "National Drug Threat Assessment 2011: Methamphetamine Movement." U.S. Department of Justice. [August 2011]. Available: http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf#page=29

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

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

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

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

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

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

Efforts to Prevent Production and Use of Methamphetamine

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

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

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

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

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

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

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

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

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

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

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

Efforts to Control Precursor Availability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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