

**THE NEW ERA IN THE FIGHT
AGAINST METHAMPHETAMINE IN IOWA**

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**THE NEW ERA IN THE FIGHT
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TUESDAY, OCTOBER 13, 2015

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., at Cowles-Kruidenier Auditorium, State Historical Building, 600 East Locust Street, Des Moines, Iowa, 50319, Hon. Charles E. Grassley, Chairman of the Committee, presiding.

Also present: Representative H. David Young.

Chairman GRASSLEY. I call the meeting of the Senate Judiciary Committee to order for the purpose of a hearing, and welcome all of you who have come. Very thankful for the big turnout for a major problem that we have here in Iowa.

For the witnesses that have had to prepare for this, we thank all of you for your preparation. I am glad that my colleague from the other House could join us; we are in his Congressional district, David Young.

I have Chris, and Tim Kelly of my staff here will be sitting behind me, and whether it is now or a year from now, you have followed up on issues like we are talking about today. I hope you will take advantage of contacting my staff when you cannot contact me, but as some of you know, I have meetings in my office the weeks that we are in session, which are about 40 or 42 weeks out of the year.

I usually reserve Mondays through Thursdays for 8 15-minute appointments for those people that come to Washington, but sometimes those are telephone meetings that I have with people back here. I am in Washington and speaking to people back here as well. I hope you will feel free to be a part of this process of overseeing that laws are faithfully enforced, but also any changes that need to be made in the law.

I am going to make an opening statement. Congressman Young will make an opening statement, then I am going to introduce each of the witnesses and we will have them testify in the order in which I introduce them. Then I will have questions and Congressman Young will have questions of these folks.

**OPENING STATEMENT OF HON. CHARLES E. GRASSLEY,
A U.S. SENATOR FROM THE STATE OF IOWA**

Chairman GRASSLEY. Once again, I welcome all of you to this meeting. Today the Senate Judiciary Committee Field Hearing is focused on the evolving methamphetamine problem in Iowa. Some

may think meth is yesterday's problem. Indeed, it seems like other illegal drugs often make the headlines more than meth. During my annual 99-county meetings, I have heard a lot from people recently about the persistence and changing nature of the meth problem in Iowa.

I am told that meth-related treatment admissions are at an all-time high, and last year nearly half of all drug—related prison admissions in our State resulted from the trafficking and abuse of meth. Meth is obviously continuing to impact Iowa in terrible ways. Today I hope to learn more about the current trends relating to meth, promote awareness of the problem and learn how the Federal Government maybe can help more than we do.

Meth is sometimes referred to as the world's most dangerous drug. It is highly addictive and can methodically destroy lives, families and communities. The children of meth users can face neglect or health risks from exposure to the hazardous chemicals that are used to create the drug.

Indeed, one of the unique aspects of meth is that it can be made at home by those addicted, simply by using common ingredients found in hardware stores and pharmacies. When combined, these ingredients are highly toxic and combustible, posing a threat to the entire household.

The risks that meth poses to families and children has been a concern of mine for many years. In 2006 I authored legislation that created a program to help support regional partnerships here in Iowa that provide treatment, services, counseling and skills training for families impacted by meth. The goal was to break the cycle of addiction and to help keep families together.

In addition, Congress began erecting barriers to meth production in 2005 when it passed a bill entitled Combat Methamphetamine Epidemic, which I was proud to co-sponsor. The law placed limits on the amount of medicines containing meth ingredients, precursor chemicals like pseudoephedrine that a customer can purchase at great ease. It required pharmacies to sell these medicines from behind the counter and it instituted a system to track sales of these substances to prevent bulk purchases.

Iowa also passed a similar State law. A few years later, one of the authors of the Methamphetamine Production Prevent Act, which became law—I was one of the authors of this Act that became law in 2008. This legislation made it easier for pharmacies to use the electronic logbooks to monitor sales of meth ingredients and for law enforcement to identify bulk purchasers.

A few years later, the Combat Methamphetamine Enhancement Act of 2010, which I also co-sponsored, strengthened this regime even further. These laws have proven to be highly effective in drastically reducing the presence of meth labs in our communities. Today law enforcement seizures of meth labs is at an almost 20-year low. The success is a tribute to the hard work here of Governor Branstad and Director Lukan.

Then, you may ask, how is meth still such a problem? Where is the drug products on our street coming from?

Some have resorted to using what is known as shake and bake, or one-pot labs to cook meth. This is essentially using a single plastic bottle to mix the ingredients. The method remains highly dan-

gerous, but can only produce small amounts of drugs, so this does not account for what is happening.

No, this is the situation today: Most of the meth in our State now appears to be coming from the Mexican drug trafficking organizations. These organizations have entered the marketplace in response to increasing difficulty producing meth domestically, and they have virtually flooded the market with the product. Between 2009 and 2014, U.S. Customs and Border Protection reported a 300 percent increase in meth seizures at our Southwest border.

The meth that these Mexican organizations are trafficking into our communities, often referred to as ice, is created at an industrial scale through a process that leads to a much higher purity than drugs produced in labs here at home. It is far cheaper as well, so it is no wonder the problem has not gone away.

We need your help to keep looking for solutions at the local, State and Federal levels. In the Senate, I lead an annual effort to maintain crucial financial support for State and local law enforcements—you people out in the field every day dealing with this danger.

Earlier this year, Senator Feinstein of California and I introduced the Transnational Drug Trafficking Act of 2015. If enacted, the bill would make it easier for the Department of Justice to prosecute Mexican cartels who harm our communities by trafficking in either meth or its precursor chemicals.

I am pleased to say that after my Committee passed the bill out unanimously, it passed the full Senate last week. We are going to do everything we can to persuade the House of Representatives that they ought to act very quickly on this bill and send it to the President.

All of our witnesses today have valuable experience and knowledge about the meth problem in Iowa. In particular, I am going to point out now but will introduce her later, the great work that our first witness is doing to support families in the crisis due to substance abuse here in Iowa.

Denise Moore is a former meth addict herself. Her story should give hope to anyone struggling with this awful problem. Once again, I thank all of our witnesses for being here and look forward to hearing their testimony. I now recognize Congressman Young for any opening remarks he wants to make.

**OPENING STATEMENT OF HON. H. DAVID YOUNG,
A U.S. CONGRESSMAN FROM THE STATE OF IOWA**

Congressman YOUNG. Thank you, Chairman Grassley, and I want to thank you for the work that you have done over the years. You are somebody who saw a problem and addressed it at the Federal level. The work continues to go at the Federal level, and there will be some help that we need with the State and locals as well, regarding this blight on our communities. Thank you for your help and allowing me to be here today.

I am not going to rattle off a bunch of statistics and a history of this, because that has already been said by Senator Grassley. I will just—I look forward to the testimony of the witnesses and the question-and-answer to help further bring awareness to this issue

and then how we combat this awful blight in our communities, which rips apart families.

This is not one of those drugs that you think about just the kids are doing, right? Adults are doing this. In their later years and for whatever reason, the hollowness in their hearts and their minds, they feel that they have to go this route. We have to be there to support them and help find a way to get them out of this. I look forward to your testimony.

Thank you, Senator Grassley, for this opportunity.

Chairman GRASSLEY. I am going to introduce our witnesses. I suppose a lot of you folks out there in the audience know these folks all right, but it is our tradition in the Senate to introduce, maybe—I already said about Denise Moore, Coordinator for the Iowa Department of Human Services Parent Partner Program. The Parent Partner Program is an approach that links parents who have successfully navigated the child welfare system with families just entering the system, to provide guidance and support.

In her work, Ms. Moore calls on her experience as a former meth addict who lost her children, but reunited with them after recovering. Subsequently, she earned a bachelor of science in human services degree from Upper Iowa. In 2011 she was awarded the Ruth Massinga/Casey Excellence for Children Birth Parent of the Year award for her exceptional service and commitment to birth parents.

Our second witness, Steve Lukan, who I knew more as a Member of the House of Representatives—but he has been in touch with my office frequently in his present position as Director of the Iowa Office of Drug Control Policy. In that role, as I am sure all of you know, he coordinates anti-drug efforts in Iowa and manages Federal grant programs focusing on reducing drug abuse and related crime. Besides serving 5 terms in the House of Representatives, he has a degree in political science from Loras College.

Our third witness, Paul Feddersen, is Assistant Director of the Iowa Department of Public Services Division of Narcotics Enforcement, a position he has held now for 3 years. Mr. Feddersen has worked in law enforcement for 21 years, largely focusing on narcotics investigation. He has an undergraduate degree from the University of South Dakota and a master's degree in public administration from Drake.

Our next witness, Lieutenant Corbin Payne: Lieutenant Payne has worked for the Waterloo Police Department for 20 years. He is currently assigned to the Tri-County Drug Enforcement Task Force, where he supervises narcotics investigations. Before that, he was a patrol officer and a member of both the Drug Crime Unit and the Citizens Response Unit, focusing on major crime problems in Waterloo. He has an undergraduate degree from Wartburg College and is a graduate of the FBI National Academy, Quantico, Virginia.

Finally, I introduce Jay Hansen. Mr. Hansen, executive director, Prairie Ridge Integrated Behavioral Health Care in Mason City, a position that he has held for a long, long time—if I am right, since 1980. He currently serves on the State Board of Health, where he chairs the Substance Abuse and Problem Gambling Committee. A past president of Iowa Behavioral Health Association. His writing

on the treatment of methamphetamine abuse was published in the National Institute on Drug Abuse Journal way back in 2007. He is a graduate of my alma mater, the University of Northern Iowa.

We will start with you, Ms. Moore.

**STATEMENT OF DENISE MOORE, DES MOINES
SERVICE AREA COORDINATOR, IOWA DEPARTMENT
OF HUMAN SERVICES PARENT PARTNER PROGRAM,
CHILDREN AND FAMILIES OF IOWA, DES MOINES, IOWA**

Ms. MOORE. Good morning. Thank you for allowing me to share my experience with you today. My name is Denise Moore. I am Service Area Coordinator with the Iowa Department of Human Services.

Chairman GRASSLEY. Maybe you should pull the microphone closer to you, please.

Ms. MOORE. Is this good?

Chairman GRASSLEY. Maybe down just a little bit?

Ms. MOORE. Is this better?

Chairman GRASSLEY. Good.

Ms. MOORE. I am a Service Area Coordinator with the Iowa Department of Human Services Parent Partner Program, employed by Children and Families of Iowa, here in Des Moines, Iowa. Parent Partners are parents that have successfully navigated the child welfare system and reunited with their children, and then are trained to assist and support families that are entering the child welfare system.

The majority of the families that come to the attention of child welfare system are due to neglect, and many of these families are affected by substance abuse. These families are often treated with a one-size—fits-all approach, no matter the severity of their addiction, resulting with their children being removed from their care. These interventions are often traumatizing for both the children and their families.

Parent Partners take a different approach. Our personal experience and training ensures a trauma-informed approach. Parent Partners have the ability to communicate and empathize with parents, building trust and helping resolve the family issues, including achieving sobriety more quickly.

I am a mother of 7 children, and had my children removed due to my methamphetamine use. From that experience, I would like to add a different perspective on today's discussion and hopefully shed some light on the desperation and hopelessness of parents affected by methamphetamine and the children that are left behind.

As a Service Area Coordinator of the Parent Partner Program in Iowa, we see families that are being destroyed by meth every day. Statewide, the Parent Partner Program is working with over 1,600 parent partners today and with the anticipation of 1,800 by the year-end.

As a parent partner, I understand the experience—the fear, the concern, the panic—but I also understand how to move beyond and achieve the goals that work, most importantly for the kids, but also for the community and the best outcomes. As a country, it makes sense to invest to help and support families at the front end. We need trauma—informed care, which is just an understanding of

where people are and where they come from and what they deal with.

It is real and used well, which changes the dynamic for families, including those suffering from addiction. We can and should help families like my family move from crisis to recovery to giving back to our community. I would like to focus today's discussion on creating systems that support recovery and allow families to heal together as a unit. To best understand this, I would like to share my personal experience.

In 2003 I was arrested for conspiracy to deliver meth after living most of my life addicted to multiple substances. I had grown up in a world of substance abuse, domestic violence, sexual abuse and drugs, and it was the only world that I knew. It was my norm. Although I wanted something different for my life, I had no idea how to accomplish that. At first it was a casual using, but then it escalated into selling drugs to finance my habit and support my family.

All the while my children were subjected to everything that I swore I would never do, including drug traffic in their home, seeing me beaten unrecognizable and being ashamed and worried about their mother's activities. My children have lost so much by seeing the people they love become incarcerated due to their addiction, but they still needed me, loved me and accepted me for all that I am.

When I was arrested, my family proceeded to immediately get me out of jail because we knew that the Department of Human Services was coming and that my children would be removed and mostly likely be sent to multiple foster homes. DHS did come, but an angel came to my door that day, and she saw my family as a unit and that my children need to be together. My mother was allowed to come into my home and I was removed in a matter of minutes. This intervention was critical to the success of not only me, but also my children.

At this time in child welfare, it was unheard of to have relative placement and for the children to remain in a drug home, but it was critical to the success of my family. My children were together; they were attending the same schools; they had the same teachers, coaches, friends. The only thing that was missing was me.

I was sent a case plan in the mail. I was homeless, with no education, no driver's license, no money, no job, and was completely alone. I continued to do what I've always known to do, and that was to continue to get high on meth. I continued on that path for approximately a year and half until I was at termination of my parental rights. My caseworker lined all my children up on the couch, including my brand-new baby, and I had to tell them that I was going to lose them forever.

My oldest son, who had loved me no matter what, had followed me, believed in me and was absolutely crushed because I was choosing drugs over him. I left that meeting and cried for the first time for as long as I could remember for all that I had done to my children, for all the pain from my own childhood and all that I have lost due to my drug addiction.

I had a meeting with DHS following that day, and I begged for one more chance. To my surprise, they said yes, since all I had heard was that once you become involved with the Department, that you will never get your kids back.

Looking back now, I see that I have seen parents' rights be terminated for much less than I have done. I vowed to stay clean, started attending AA meetings, started going to college, got a job, slowly had my children returned to me, and I have been clean from drugs for over 10 years. I was successfully reunified with my children after being away from them for 18 months, and my case was closed after 2 years. Since then, my children and family have overcome challenges and withstood many barriers and have become outstanding members of society.

My children have broken the cycle of addiction and they have gone on to have amazing and wonderful lives. They have healthy relationships. Four have graduated high school. They are going to college, buying houses, and building families.

Unfortunately, these outcomes and interventions are the exception, and not the rule. We need more substance abuse treatment programs that focus on keeping families together. Support also is needed for relatives that step in to take care of our children. My hope is that we will recognize that incarceration and removals leave a trail of destruction for families in their path. I am proof that parents with meth addiction can recover and create nurturing and stable homes for their children.

No one wants to be addicted to meth, but most people do not know how to stop. Through my work with parents and families, both across the State and Nationally, I have seen many children that are growing up without their parents or extended families and have been taken away from their communities.

It is critical that we start looking at these families as a whole, and wrap services around them so they heal together and have healthy, stable lives that are drug-free. Thank you for all your time, and I would be happy to take any questions.

Chairman GRASSLEY. Thank you, Denise. You are a brave person. Thank you for your story, and I hope it is an encouragement to other people as well. Now, to Director Lukan.

**STATEMENT OF STEVE LUKAN, DIRECTOR, IOWA OFFICE
OF DRUG CONTROL POLICY, DES MOINES, IOWA**

Director LUKAN. Thank you, Senator Grassley, and thank you, Congressman Young, for being here today. I particularly want to thank you, Senator Grassley, for all your clear and consistent leadership on drug issues. You have been a leader in Congress, and the work that you have done has really been beneficial to so many Iowans, but also so many Americans as well.

I want to talk a little bit today about one of the big challenges I think we face in the whole battle against drug abuse, and meth in particular, is that there is a relaxed attitude, or seems to be more of a relaxed attitude, in the general public that the battle against drugs is unwinnable and deserves rethinking.

[Inaudible]—can understand the concerns of many, I do want to share one example similar to Denise about how things have gone right. Several years ago I had the opportunity to meet a man who was addicted to meth. The drug had crippled his ability to earn a living. He resorted to breaking and entering to support his habit.

Distraught and fed up, his wife kicked him out of the home and he had lost all contact with his child. Still this drug held so much

power over him, and he could not see a reason to change. Time and time again, people told him he needed help, he needed to change his ways. He had lost so much, but nothing sunk in until he was actually arrested and placed in handcuffs and sat in the back of a police car. It was then that he told me he finally realized he needed to change.

He dried out in jail for several months. He committed to a treatment program that eventually had successful outcomes, and today this man holds a full-time job as a computer technician. He has got the love and support of his family again, and he actually goes and does things on the weekends, like enjoys long bike rides.

I think that this is an example that when we do have strong laws and law enforcement working together with access to quality treatment, we can defeat this and many other drugs. Another area of success I would like to share is the prevention programs that are out there working in our State. I am very happy to report that Iowa youth roundly and soundly reject experimenting with methamphetamine.

Statistics show that approximately 1 percent of Iowa youth have experimented with the drug, and while I believe that this number should be zero, I am pleased that educators, parents and the prevention professionals work hard each day out there to teach young people about the dangers of this drug.

I believe when children and young people are fully informed about what this drug can do to their bodies, they will choose to avoid it. They will choose to live healthy lives, and this can greatly improve their ability to be successful in life. Even so, we must recognize that meth is arguably the most problematic drug in Iowa. It is closely linked with cases of child abuse and neglect, crime, gun violence and incarceration in our State.

Our office uses Federal Byrne JAG funds to partner with multi-jurisdictional drug task forces around the State of Iowa. These task forces serve as the front line of defense against the powerful drug methamphetamine.

Last year these task forces seized hundreds of firearms that were involved in meth activity, and also referred hundreds of children to the Department of Human Services for care because of neglect and abuse in the home, much of which was linked to meth abuse.

As Byrne JAG dollars coming to the State of Iowa and other States has decreased, these task forces have had to ask for more support from local governments. Thus far, many local governments have stepped up and helped support these efforts, but I would like to stress that only so much can be done from the local level.

The Federal Byrne JAG dollars that come to our State have proved to be the crucial glue holding many task forces together. I would ask for continued consideration of these dollars, because they do prove to be a crucial multiplier effect in the battle against meth.

Other challenges we face in the battle against meth include legal rulings which make it more challenging for law enforcement to disrupt drug trafficking organizations and confusion in the public about the best approach to defeat drug abuse.

I believe it is time to reaffirm our opposition to this and other harmful drugs, while at the same time ensuring access to treat-

ment programs that can help people turn their lives around and become productive citizens once again. We also need strong prevention programs that educate and empower young people to make healthy choices for their future.

We should also applaud combined efforts which have helped decrease meth labs in our State from over 1,500, as you noted, to well below 200. This is not an insignificant achievement, and we have many partners to thank.

However, as you will hear others express, cartel activity that spans Mexico and the United States has helped to fill the void with very pure and powerful forms of meth being found across our State that has been trafficked in from south of the border.

The United States should revisit the issue of meth precursor control agreements with Mexico, as it appears the current system has not been effective in thwarting production of the drug in Mexico. We also need the commitment of Federal partners to help stop the flow of this dangerous drug across our Nation. Let me end by again thanking you, Senator, for holding this hearing to gain insight into the challenges we face. I appreciate Congressman Young being here as well.

I believe that strong law enforcement efforts, coupled with quality prevention and treatment programs can work to defeat the menace of meth in our State. I look forward to being a resource to you and our Federal partners as we face this challenge together. Thank you.

Chairman GRASSLEY. Thank you, Director Lukan.
Now, Mr. Feddersen.

**STATEMENT OF PAUL FEDDERSEN, ASSISTANT
DIRECTOR, IOWA DEPARTMENT OF PUBLIC
SAFETY, DIVISION OF NARCOTICS ENFORCEMENT,
DES MOINES, IOWA**

Director FEDDERSEN. Thank you. I am just going to go through and kind of tell everybody where we have been with methamphetamine and where we are at today.

Domestic manufacturing of methamphetamine in Iowa still remains a threat. As stated before, State and local methamphetamine clandestine laboratory responses for calendar year to this date is approximately 113. This is a significant decline since the peak in 2004, where there were approximately 1,500 annually.

As stated before, in 2005 the Iowa Legislature passed legislation limiting the availability of pseudoephedrine, which is a key ingredient in the illegal manufacture of methamphetamine. Currently the problems of methamphetamine labs is the emergence of the one-pot cooks. These methods generally use less pseudoephedrine, produce methamphetamine in smaller quantities, but are no less dangerous than other production methods.

Toxic chemical fires and explosions are significant health and safety risks associated with these methods. The remnants can easily be transported in a vehicle, disposed of in neighborhoods and ditches. Aside from its environmental impact, serious hazards exist for children who come in contact with the waste, or families impacted by the flash fires from these cooks.

The average cost of a clandestine laboratory cleanup, paid for by the Drug Enforcement Agency's hazardous waste contractors nationwide, is now approximately \$2,700 per laboratory. There are also hidden costs as well. For example, State and local law enforcement agencies that seize these laboratories must leave personnel onsite until the laboratory is cleaned up, and often resulting in overtime expenses and lost productivity in other areas.

To assist our local law enforcement partners with the financial burden of the cleanup of clandestine laboratories, the Division of Narcotics Enforcement implemented the DEA's Authorized Central Storage Container Program.

This program is sponsored by DEA and allows trained, certified law enforcement officers to remove gross contamination from clandestine laboratory sites safely, package the waste pursuant to Federal, State and local laws and regulations, and transport it to the secure storage container where it is stored until a qualified hazardous waste contractor can remove it for disposal.

The DEA provides storage containers, safety equipment and cleanup materials at no cost to Iowa law enforcement. The Division of Narcotics Enforcement coordinated this program and is partnered with local law enforcement agencies to strategically place 5 of these containers on law enforcement-controlled properties throughout Iowa. This program is very effective in saving law enforcement time and money in the cleanup of methamphetamine laboratories.

Although domestic manufacturing of methamphetamine remains a threat, the majority of the methamphetamine is produced in Mexico and smuggled across the Southwest border. Major drug trafficking organizations, also known as DTOs, are undoubtedly the largest contributing factor to the supply of methamphetamine in the State of Iowa.

Mexican DTOs are the primary organizational threat to the State. They are responsible for the management of sophisticated smuggling, transportation and distribution networks for methamphetamine, not only in Iowa but throughout the U.S.

The Division of Narcotics Enforcement has experienced a significant increase in major cases involving large quantities, meaning kilo quantities, of seizures—appear more potent than methamphetamine smuggled into Iowa from Mexico and other states. The Division of Narcotics Enforcement is on course to seize double the amount of methamphetamine that was seized last year.

The most recent report for the Iowa Division of Criminal Investigations Crime Lab reports the average purity level of methamphetamine confiscated in Iowa today to be 98 percent. That compares with an average purity level from 10 years ago of 14 to 40 percent.

With the large quantities of high-purity methamphetamine flooding Iowa, there has been a significant decrease in the price of meth. In 2009, one pound of methamphetamine could cost anywhere from \$27,000 to \$32,000. Today the price for one pound of methamphetamine is \$10,000 to \$14,000.

The State of Iowa sits in the heart of the Midwest, crisscrossed by the Interstate 80 and 35, connects the east and west coastal re-

gions of the United States and provides an international corridor for the drug importation and distribution for DTOs.

A recent example of this is a trooper from the Iowa State Patrol was conducting traffic enforcement on the Interstate system and recovered approximately 37 pounds of methamphetamine. The Division of Narcotics Enforcement and our local drug task force partners in Iowa have also identified drug-endangered children as a priority. Officers have received drug-endangered-children training, also known as DEC, and most task forces have implemented formal multi—jurisdictional DEC teams.

The DEC teams incorporate the principles of substance abuse, prevention, intervention, treatment, child protection, prosecution and drug enforcement to protect children from drug users, dealers and manufacturers. The DEC program, coordinated by the Office of Drug Control Policy, features law enforcement officer working side by side with DHS workers, prosecutors, court officials and health care providers toward a common goal of protecting children.

DEC is the model that is being adopted by Iowa communities helping interested entity stakeholders join together as a safety net for children, and a way of encouraging custodial parents to deal with their addiction so that families can be reunited in healthy ways.

The Division of Narcotics Enforcement—for most joint cooperative investigations that often cross jurisdictional lines. Experience clearly demonstrates combining the knowledge, expertise and resources of many agencies and jurisdictions are the most effective and cost-efficient methods of conducting large-scale investigations of major traffickers.

Chairman GRASSLEY. Thank you, Mr. Feddersen. Now, Lieutenant Payne.

**STATEMENT OF LIEUTENANT CORBIN PAYNE,
WATERLOO POLICE DEPARTMENT, TRI-COUNTY
DRUG ENFORCEMENT TASK FORCE, WATERLOO, IOWA**

Lieutenant PAYNE. Thank you, sir. I just want to get my opportunity to speak here. Thanks for that and the support you have given our task forces over the years and, hopefully, continue to do.

I am just going to give you a little background about the Tri-County Drug Task Force and how methamphetamine is affecting the Northeast Iowa communities that we deal with. A little history of the Tri-County Drug Task Force: The Tri-County Drug Task Force was developed in 1991 to combat illegal drug trafficking in Black Hawk and Bremer County areas. The Task Force is federally funded by the Byrne JAG Assistance Program Grant since its inception.

The Task Force agency involvement in coverage areas: The assigned area is a rough responsibility for the Task Force, comprised of a lightly populated rural area with a densely populated urban areas contained within a geographical area of approximately 200 square miles and a population base of nearly 170,000, with a diverse mixture of ethnic, cultural and socioeconomic backgrounds, these areas include the cities of Waterloo, Cedar Falls and supported cities within the Black Hawk County and Bremer County

areas, which also include the following cities of Waverly, Hudson, Evansdale, La Porte City and also the University of Northern Iowa.

The Task Force is comprised of full-time investigators, a supervisory staff from the Waterloo Police Department, investigators from Cedar Falls Police Department, Black Hawk County Sheriff's Office—and an analyst with the Iowa National Guard provides excellent resources for these investigators involved. Task Force investigators maintain a close working relationship with Iowa Division of Narcotics Enforcement, the Department of Corrections, and continuous dialogs with the Department of Human Services to better track child endangerment and treatments as it relates to illegal narcotics offenses in our area.

Investigators with the Tri-County Drug Task Force maintain a constant working relationship with several Federal law enforcement agencies, including ATF, ICE, DEA, U.S. Postal Inspectors, the U.S. Attorney's Office and, in particular, the FBI, due to the fact that the FBI maintains a regional office in the Waterloo area that provides great resources and support in many of the Federal drug cases the Task Force investigates.

Duties and operations of the Tri-County Drug Task Force: These investigators of the Drug Task Force investigate multi-areas of major narcotics trafficking and manufacturing at both State and Federal levels. These areas include, but are not limited to, the illegal sale and distribution of methamphetamine, crack cocaine, cocaine, high-grade marijuana, heroin, hash oil, prescription drugs and the investigation of firearms commonly associated with the distribution of illegal narcotics.

Because of the number of cases being investigated, considerable resources are needed to investigate, apprehend and prosecute the subjects involved. Different law enforcement agencies and enforcement techniques, strategies and operations are required as the type of drug being investigated changes.

Through use of combined resources and technology, the Task Force continues to advance our success rate in crippling and destroying criminal drug distribution organizations and networks. The destruction of these criminal organizations successfully disrupts the importation of significant amounts of methamphetamine—in particular, ice, high—grade marijuana, crack cocaine and cocaine into our area. The shared intelligence, investigation and partnership continue to reap benefits in our efforts against the drug distribution networks.

Methamphetamine in Iowa: Over the last 10 years, the method of methamphetamine manufacture and distribution has changed significantly in our area. Home-based methamphetamine labs have experienced a drastic decline in recent years, due in part to the enacted State statute limiting the sale of precursors, specifically pseudoephedrine. Labs do still present a significant threat to local communities when they are discovered. When the decline of large home-based labs began to decrease, the more transportable and concealable one-pot methods of methamphetamine began to rise.

This is a more convenient way of making meth quicker and does not require clandestine lab-type items to make the meth. This type of cooking results in a lower-yield meth with a lower purity level. These one-pot-cooks-all also have become more of a hazard to the

public because of the way these chemically—laced vessels are discarded, due to the fact these transportable items are often discarded in public areas and streets, ditches and parks.

The Tri-County Drug Task Force methamphetamine lab seizures, as far as what were submitted, and far as the pseudoephedrine act law—and I will determine those when I get to them—but in 2003, the Tri-County Drug Task Force seized, reported 112 methamphetamine labs submitted; 2014, 117 labs. This is just in Black Hawk and Bremer Counties alone.

Due to the Pseudoephedrine Control Act enacted in the middle of 2005, we decreased down to 74 labs. In 2006, there were 30 labs submitted. In 2007 to 2011, those numbers stayed about the same. In 2012, 72 labs, the increase mostly due to the one-pot methods that were on the increase because of the decrease in the larger labs. 2013, also 31 labs, also mostly one-pot methods. As to 2014, we have in our area only 8 labs reported due to obviously the increase in ice methamphetamine, that I will get into.

Methamphetamine ice continues to be one of the largest problem drugs in our area in recent years. The Task Force is very active investigating large Mexican drug trafficking organizations. These organizations have been a major threat not only to our area, but to Iowa and the Midwest as a whole.

During the meth investigations, we have determined that massive amounts of ice methamphetamine has either been transported by vehicle or shipped to the Black Hawk County and surrounding areas for organizations within Mexico and California. During our investigations from 2012 to present, the Task Force has seized over 70 pounds of ice methamphetamine, with a street value of over \$4 million.

This task force is currently working these investigations along with a number of agencies, including the DNE, Homeland Security investigations, the FBI and the U.S. Attorney's Office.

During our investigation we have learned through the State crime lab that the test results coming back from this type of methamphetamine test at a rate of 97 to 98 percent pure methamphetamine, which is no difference between the home-based labs that we had a—result in investigating back in—about—70 percent methamphetamine purity level.

The price consistent with the sale of ice methamphetamine or regular methamphetamine that we deal with in our area is ice methamphetamine's worth about \$120 to \$150 a gram, and the home-based, one-pot anywhere from \$60 to \$100 a gram. In conclusion, as I have indicated, clandestine labs and one-pot methods still pose a significant threat, not only to the investigators working these cases, but also to citizens in the community that may come across them and have contact with them.

Toxic chemicals, fires and explosion remain a constant concern for the safety of the community and anyone involved that are exposed to these types of situations. It is evident that the importation of ice methamphetamine to Iowa has become a major issue, not only to the law enforcement community, but the community as a whole.

The large amounts of money being made, weapons being seized, along with the huge supply and demand in this area of a highly

addictive drug requires a continued funding of these supports and the vigilant efforts of not only treatment but for law enforcement. Thanks for the time and the opportunity to present this information.

Chairman GRASSLEY. Thank you. Now, Mr. Hansen.

**STATEMENT OF JAY HANSEN, EXECUTIVE DIRECTOR,
PRAIRIE RIDGE ADDICTIONS
TREATMENT SERVICES, MASON CITY, IOWA**

Mr. HANSEN. Senator, Congressman, thank you for this opportunity to testify. Before I do start my remarks, I do want to thank you, Senator Grassley, for the work that you have done with the Drug-Free Communities grant.

I was contacted by several people prior to coming here, and they wanted me to express their happiness about what you have done in our area. Even though the grants have run their course, coalitions are still operating, doing a lot with environmental, and the data is there to back it up. You have laid a foundation for the future, and I just wanted to thank you for that.

Chairman GRASSLEY. Thank you.

Mr. HANSEN. Addiction is difficult to understand. It is very complex. When I was going to the University of Northern Iowa as a social work student, a friend of mine was living in a family with alcoholism. I had never seen anything like it before. It certainly was not like my family.

The tears and the difficulties and the losses and the employment issues and the conflict and the heartache in that family really kind of grabbed me, and I wanted to go in that direction in my career.

As people continue to use substances in spite of negative consequences—that is a powerful statement. Continue use in spite of negative consequences kind of says that the punishments or the negative things do not seem to make a difference with the addicted person. That mystery, I was interested in trying to find that out.

In the past 15 years, largely through the work of the National Institute on Drug Abuse, Dr. Nora Volkow and others have done a lot of brain imaging and studies of the brain. I think we have the answer to that mystery at this point, and I think it was important for me to talk about that today.

Dr. Volkow focused on the limbic and the reward system of the brain. It is the place where it is the most primitive part of the brain. It is responsible for helping us survive throughout life by rewarding important activities that will help us survive as a species.

Food tastes good because it needs to be rewarded so that people do not starve. Procreation is pleasant because we need to continue to have babies in this world, if our species is going to survive. Water tastes good when you are thirsty because you have to have water to live. Nurturing newborn children feels good because we want that to happen. This is a very powerful but primitive part of the brain, and what NIDA has found is that the culprit is a neurotransmitter called dopamine. Dopamine is responsible for most of the pleasurable feelings we experience, and substance use and addiction involve action releasing amounts of dopamine in one form or the other.

In essence, addiction is a brain disease. It is, I think, when families experience people using, in spite of negative consequences, they do not know the answer to that mystery and oftentimes they will say things like, “They must care more about that drug than they do me,” “How could you give up your kids to methamphetamine?” “You must be a weak-willed person.” Unfortunately, that sometimes is the characterization of persons with substance-use problems, without that question answered.

Dopamine is the grandfather of all reward drugs. Studies done with animals set a baseline level of dopamine at 100. Having sex produced a change from 100 to 200, cocaine from 100 to 350 units, and methamphetamine 100 to 1,250 units of dopamine. It is hugely rewarding. People trying meth for the first time describe it as going in a casino for the first time, pulling the lever one time and winning the super jackpot. That is how powerful and rewarding it is.

The reason we have problems with drugs in this country is that they work. They make people feel good. That reward makes it difficult for them not to return to that process.

When the dopamine is being flooded in an addict person’s brain, it is so interesting that the brain will immediately try to heal itself through homeostasis. The brain says, “Whoa, this is too much of a good thing. I need to do something about this,” and immediately will begin killing off production of normal dopamine and reducing receptor sites where the dopamine locks in and creates those pleasurable effects.

Once a person starts using methamphetamine, their natural production of dopamine is lowered and their receptors that pick up dopamine are also lowered. What they get is less dopamine in their system than they had when they started using. Then you have this compulsion to start seeking more dopamine because your body has added this level of drug to those primal issues of food, procreation, water and nurturance. There is another layer that they are having to deal with with an extreme drug hunger.

It is one thing to try substances because you like them. You try them and it feels good. Most people end up in a drug career where it is not about liking drugs; it is about wanting drugs, from a biochemical standpoint. The best definition of addiction that I have come across is “an irresistible urge to perform an irrational act.” If you take some time to think about that, it is a very powerful statement: irresistible urge to perform an irrational act.

While I know it is not the right thing to do, I cannot help myself from doing it. It is really good and, I think, indicative of this issue of continued use and responsible for—in negative consequences.

Imagine you are underwater 200 feet, and you are beginning to make your way to the surface, and you know that if you breathe underwater you are going to die. Yet you breathe, because it is irresistible to do so. That is not a perfect analogy, but it is a good analogy for this compulsion in addiction.

What moderates addiction and treatment? Treatment is really about dealing with that primitive brain area and the executive function up here. The reason the description of what exactly executive function does is actually a battle between the reward system and the executive function.

That is what treatment really ends up being. We are trying to help people learn skills, understand biochemistry in their situation, their health, put skills in place, put supports in place, put relapse prevention skills in place so that we can make the irresistible desire to do something resistible. In treatment, that is what we are trying to get to—make irresistible resistible so that people have the skills and tools to resist that brain that now has another hunger to it.

I think sometimes substance use-disorder clients get kind of a bad rap that they are not motivated or they are not responsible or interested. Let me tell you, folks—and I am sure this is the case with Ms. Moore—is people who overcome this hunger on a daily basis are some of the most courageous people that I have ever met in my life.

The good news is in Iowa, Iowa has done outcome studies for many years. Methamphetamine treatment is a little bit more effective than even other kinds of treatment. People do recover, and in this process of treatment there is also now, I think, some exciting additional tools to use, moderating the primitive side of the brain that moderates some of those cravings and urges.

Those things will change over time, and cognitive functioning will improve. It does take time. That is really the biggest difference in methamphetamine treatment, is people need time to rest and get sleep and eat and get a toehold so that we can start providing them with skill building and other kinds of therapies.

It is also important to look at their recovery environment. People will need people in their life that support them, and that is one thing that we focus big on in treatment. That is where Parent Partners is such a valuable resource for us in our specialized methamphetamine treatment programs. With that, I think I will conclude my remarks and turn it back to the Senator.

[Applause.]

Chairman GRASSLEY. Thank you. Thank you all very much. I appreciate your testimony.

I have a lot of questions. Some of my questions have been answered by some of your testimony, and some of my questions might refer to your testimony in asking for a greater expansion on some of the things you said in the short minutes that we gave you.

Also, so I do not forget it at the end of the meeting, we put out an announcement in the press when we announced that we were having this hearing, that we had the witnesses that we have, but anybody that wants to submit written testimony to the Committee can do that. We usually give how many days? [Staff speaks off mic.] About 10 days from now. If anybody wants anything in the Committee record, and the Committee record will be printed and available for distribution, then in 10 days submit that to the Senate Judiciary Committee.

I am going to start with Ms. Moore. Obviously, you have an incredible story. Meth is an awful drug. Your presence here today and the work that you are doing shows that there is hope that meth addiction can be overcome. My first question has several parts, but I am going to read them all at once. Can you walk me through how the partners program works here in Iowa? When does a parent partner enter the process? What sort of things can they

do for a parent whose children have been placed in foster or kinship care, and how do they interact with other players in the child welfare system?

Ms. MOORE. Okay. I will kind of walk you through a case in how it works in Des Moines, and it is similar throughout the whole State, how we get referrals. As soon as a child is removed, the worker notifies a Parent Partner coordinator and we try to match a parent partner with the same culture and whatever issue has brought them into the system.

In Des Moines, we have an initial family team meeting, and it is called a pre-removal conference. Sometimes they are kind of changing that now. At that meeting, either the family has just had their child removed or they are just going to have their child removed. It could be pre-or post-

At Parent Partner we get an email and the Parent Partner comes to the meeting. There is like no identifying information that is given to us, because we have not had a release signed. Then the Parent Partner meets with the family. They have an instant connection with the family because of the shared experience of having their child removed.

Also, as we match similar issues, so whether it was domestic violence, they understand that kind of process. In substance abuse, of course, they know what the next steps are and they understand that process as well.

Families come in very scared and fearful of the system. Everybody looks the same. Everybody looks like workers to a family that is coming into the system, and a Parent Partner can just come in and say something, for example, like I have had my child removed due to my substance abuse. Today, I have all my children back with me, and I want to walk through this process with you.

The Parent Partner then walks through the entire life of the case with the family. They are going to court hearings, they are doing face-to-faces, they are going to family team meetings, they are helping them to have more interactive family interactions with their children, they are connecting—to community resources, they are helping them to understand the process.

The process for families is very confusing, and it is somewhat of a different language when you are sitting in a court hearing or you are sitting around a family team meeting. Parent Partners are able to kind of relay what that information is for the families, so they are able to understand what is actually happening and what the next steps need to be.

Our Parent Partners are really do it for do it from the heart. A lot of their giving back is part of the recovery, so they really provide hope for families. I think that is the most important thing that we do.

Families are very hopeless and feel very hopeless when they come to the doors of the Department, and Parent Partners can shed some light on that and inspire families to start moving forward. They really are just connecting them with the system, helping them to engage with their workers. We know it is critical to families being successful and being reunified with their children, so we are constantly engaging.

Parent Partners do not report to the courts or DHS workers, so there is that foundational trust between families and Parent Partners.

Chairman GRASSLEY. How long has Iowa had this program, and do other States do it?

Ms. MOORE. We have been—started in 2007 in four pilot sites across Iowa, and then we have implemented it. We started with an implementation center, a Midwest Child Welfare implementation center in 2008, I believe. Then we started spreading the program. It was a lot of years of building trust within the Department, that we are not trying to triangulate or do anything with families that would hurt them or hurt the system. We did a lot of trust building for years.

In 2013 Iowa Department of Human Services put it into a State-wide contract with Children and Families of Iowa in that we are in all 99 counties across the State. What was the other part of the question?

Chairman GRASSLEY. Do you have data on—oh, the other States, have adopted it?

Ms. MOORE. Oh, yes. Yes. We are currently working with, I believe, 9 states. We have worked previously with around 13 states. It is really a National movement, and Iowa is looked at as a leader in this work. A lot of States have modeled their Parent Partner Programs after ours.

We have developed all of our documents, all of our programming policies has all had the parent voice incorporated into it. It is a model for the rest of the States, and States all across the Nation are looking at it.

Chairman GRASSLEY. Okay. Do you have any data on the effectiveness of the program?

Ms. MOORE. Yes. We have added evaluation by the University of Nebraska. It was a 5-year evaluation. They took—it was a quasi-experimental design, and so there was many facets to our evaluation. One of them was they were developing a data base we put data in. We have surveys, entering and exit surveys that measure protective factors of families and parents.

Then they did focus groups within our Department all the way up from our Child Welfare administrators, our frontline workers. Focus groups are our parents and our families, and then they took administrative data from the Department and matched it with our data base, our families that do not have a Parent Partner. It was found that families that have had a parent partner are more likely to reunify and they are less likely to come back into the system.

Chairman GRASSLEY. Okay. I would like to ask Director Lukan a question and then I will turn to David. I do not sit on the Senate Appropriations Committee, but as I mentioned earlier, each year I lead a bipartisan effort to help maintain the Byrne JAG funding that helps your efforts in the State of Iowa and local efforts.

Obviously in these times when the Federal Government is running huge deficits, it is an uphill battle each year. I want to give you an opportunity to explain to Congress the significance of the funding for your program and what you know about it throughout the State, how critical is it, what types of things does it pay for,

and is the Federal Government getting its money's worth with these dollars?

Director LUKAN. I will maybe, take the last question first. I know that certainly all dollars have to be used very wisely, especially with the way the Federal deficit has grown. We want to make sure we are making effective use of taxpayer dollars.

I think the numbers from what we do at the Byrne program really speak for itself. For example, Statewide last year we had over 400 drug trafficking organizations that were interrupted, that were dismantled or interrupted. We had almost 600 firearms that were taken off the streets that were used in illegal activity and drug trafficking and in other crimes.

I feel like this is a very wise use of the resources, and I think that the numbers are speaking for themselves, not to mention also the number of children that our Task Force has referred to Human Services. Over 300 kids that were living in very dangerous situations were referred to help to try to get them moving in the right direction, as Denise and others have shared, get the families the help that they need. I feel as though the money is used wisely.

By and large, what—and others that work on the ground, feel free to jump in—but oftentimes what we see is I think the value of these task forces is the multi—jurisdictional approach. What I mean by that is you have multiple counties in a region instead of one community thing. This is my problem here; they are working together. There is an incentive to get together; the funding can come in and help.

They actually have to apply to our office, the competitive program. And we have become much more competitive in the last few years that the dollars have gotten tighter. It is a competitive grant program. I think it gives an incentive for communities to come together and say, let us fight this in a regional approach. Again, I think that there is a lot of value there. There is information sharing. I think that is a real important tool.

More and more today, my understanding is it is trying to work things up the chain. It is not just making the small arrests by the roadside; it is trying to find out where are these coming from, who is pushing them into our communities, how do we disrupt this organization? So, the multi-jurisdictional approach, I feel, is very effective.

What I would say as far as the dollar values, a number of years ago I sort of likened this to being the cake that was the incentive. Our office would provide a KCU to get together. The local governments would then have to put the icing on that. By that I mean some of the overtime dollars, equipment dollars, overhead costs.

Today, as the funding has gone down, that role has reversed. A lot of times the local governments will be incentivized to put a cake together. They apply to our office for the icing. We are sort of taking on more of that role of helping pay for the overtime costs and other things.

We have had a lot of challenges, as I have mentioned, as the dollars have gone down. Certainly we support your efforts and the Congressman's efforts. I know that without your action, we would be in probably even a tougher position.

Maybe the last thing I would share is that it does not always have to be increased dollars. I think just being able to know that there is sustainability is an important thing. We have actually had a number of task forces disband because the numbers did not work anymore. I think having stability is important. Also, there is a number of ways that we can maybe work together to find further efficiencies on the Federal level. Maybe there is things that could be rolled into the Byrne formula is an idea that we have shared in the past too.

Chairman GRASSLEY. Okay. Congressman Young. I will have questions after he gets done.

Congressman YOUNG. Thank you, Mr. Chairman. Being on the House Appropriations Committee, I take note of your support, your support as well of the Byrne program and its effectiveness. Thank you for that. Mr. Hansen, you spoke of the irresistible urge to perform an irrational act, and folks continuing to use, despite the negative consequences.

You went through that, Ms. Moore. That monkey was on your back for a longtime. Your story is very compelling, your personal story. You went through this without a partner, right?

Ms. MOORE. Right.

Congressman YOUNG. How did you do that? How did you make your way through this without that support that a lot of folks are getting through your partnership program that you are involved with? How did you do this?

Ms. MOORE. I think for me ultimately it came down to the love I have for my children. When it came to the point that I was going to lose them forever, I finally realized that I was going to lose something more important to me than methamphetamine, at that point. That was my motivator and that is how I changed.

When I first came into the system, it was not like I just said, Okay, I am going to get clean now. I languished out there for a long time, and that is why I feel so strongly about working at the front end of cases, and even before that in some preventative services, because we need to become that connection from the very beginning to help motivate our families to get clean.

Because if we give them a chance, they are going to go right back and do the same thing that they have always done. That is what I did for a year and a half. I wasted a lot of time that I could have been working in recovery, and I was just out getting high again. I think ultimately it was the motivation of loving my children so much and losing them.

Congressman YOUNG. This may be the exception rather than the rule in these instances.

Ms. MOORE. Absolutely. I would say even in 2003 it was really an exception in the rule because at that point there was not really a big push for relative placement. My hope was considered a drug home.

For them to kind of look out the box and see what is the best thing for this family and think and look at my children and see that the needed to be together, they needed to be in their schools, they needed each other, was huge. Because I had so many kids, they would have been split and put in different foster care homes.

That was the critical piece for them. They needed that piece to be who they are today, to break that cycle.

Congressman YOUNG. It is testament to the power of love.

Ms. MOORE. Yes, it is.

Congressman YOUNG. Mr. Hansen, in listening to all this, it seems like the recipe of empathy seems to be important when it comes to treatment and counseling. That is, having somebody involved in the process who has been there. Tell me about that effectiveness—it is more successful than not.

Mr. HANSEN. I do not believe any treatment is successful without someone having a relationship with another person that expresses hope for the person and genuinely care for the person. We spend a great deal of our time at Prairie Ridge focusing on that initial relationship. We measure it, from time to time. Is the person engaged? Are they getting better? You are exactly right. Human being to human being.

What I tell our counselors is I am not worried about any other outcome when people come here for the first time, that when they leave their office they have a sense of hope and they want to come back. That wanting to come back is about that relationship.

Congressman YOUNG. Thank you for that. Can I ask another one?

Chairman GRASSLEY. Yes.

Congressman YOUNG. Lieutenant Payne, you talked about the traditional labs as we have known them as kind of going down, decreasing. We are seeing these new, almost portable shake-and-bake labs, right? You can do them anywhere, on the go, wherever you want.

I think you talked about ice. Do we know for sure that this is being transported in? The purity that you talked about, this 97 to 98 percent, do we know for sure that this is coming over the border or from out West somewhere, or could this be being developed here in the heartland and we just do not know about it?

Lieutenant PAYNE. No. Through our investigations, it is particularly coming from over our borders. Investigations and the cooperation we have had from several of our people during their investigation we have come in contact with are associated with it being transported in over our borders—the California area.

Congressman YOUNG. Okay. Thank you. Senator, go ahead.

Chairman GRASSLEY. Okay. Mr. Feddersen, you know that meth labs, even small one-pot labs, contain toxic chemicals that are harmful to the health of those around them and to the environment. My question, I understand that the DEA container program has been instituted here in our State to help dispose of labs that are encountered in the field. Would you describe how the program works, step by step? Is it operating effectively today?

Mr. FEDDERSEN. Yes. I will tell you what. DEA has been a great partner for the State of Iowa, not only on the meth labs, but in the methamphetamine investigations that cross borders. They are a link to follow up on these cases.

Regarding the meth lab container program, that container program, they make it easy, DEA. We contacted them; they want 1 Representative from the State for their contact, and we contacted them. They provide the storage facilities. It is a 7-by-7, basically

a moving container that several local law enforcement agencies volunteered to put on their property.

DEA provides the training to package this material and put it in these containers, and also the items used to package those. It has been great here in Iowa. We have got 5 strategically placed throughout Iowa. Any law enforcement agency can come and utilize those labs to drop those remnants off, package them and put them in that container program.

We have had it—I misquoted on my written documentation. I put 2014, but it was actually implemented in 2015. We started the process in 2014. Since July to currently, this date, we have had about 52 labs that have been put into these container programs.

By doing the numbers, that would cost local law enforcement about \$140,000 on average to clean up those labs, and that is just on the cost of the lab. That is not on the cost of the overtime, waiting for a contractor that would come out of St. Louis in the past to clean up those meth labs.

It is so easy for law enforcement to get that lab, take it to a container, put it in there, and then once that container is full, one of the agents with the Division of Narcotics Enforcement has a contact at DEA. DEA calls a contractor, and those containers are emptied out, no cost to local law enforcement. It has been a great project for the State of Iowa and local law enforcement and for the taxpayers. It has been working great so far.

Chairman GRASSLEY. Mr. Hansen, I understand that the medication assistance treatment holds some potential promise on meth addiction, so I would like to have you explain what this kind of treatment is, where it is in the development, and how it could act on the brain to treat meth addiction.

Mr. HANSEN. I talked about the executive function being more treatment. We have not had much to help us with that brain, mid-brain function. In the past years there have been a number of drugs developed—naltrexone, which is an antagonist, which actually goes in and fills those receptor sites that would release dopamine, effectively blocking the drug from being absorbed. You can take it daily by pill or you can actually inject it monthly.

Naltrexone also is an opiate antagonist where—so if you have naltrexone in your body and you take opiates, there is no effect. It is also used—naloxone is the spray that they are giving people who are overdosing, which will immediately bring them out of the overdose. Campral is a drug that reduces cravings by acting on those neurotransmitters.

Suboxone is a drug that we are having very much success with. It is a partial agonist mixed with naltrexone, so it can be of use—so persons with serious opiate problems can take this drug. It is a partial synthetic narcotic, but it does not have any—it just gets rid of the cravings.

I have seen people come from our program that were writhing in pain, having a disorganized life, stealing, and the next day after getting their suboxone, get up and go to work and function perfectly. Unfortunately, we do not have a drug for stimulants yet. I know Dr. Volkow at NIDA is working on it, and so one thing that the Federal Government could do would maybe have someone check into what the status of that is.

There is some research on developing vaccines where a vaccine will be produced and given to a person at some point, and the effect of drugs would not be occurring. That is exciting, because it acts on those neurotransmitters and gives us, the research says, about a 26 percent improvement in outcomes.

Everyone at Prairie Ridge, if they are eligible, they are getting informed of the availability of those drugs, either through our prescriber or their primary care physician.

Chairman GRASSLEY. Okay. Director Lukan, foreign drug trafficking organizations do not just distribute finished meth products; they also manufacture and distribute precursor chemicals. You mentioned in your written testimony the idea of revisiting the issue of meth precursor control agreements with Mexico. I think that has merit.

One of the things that my bill, the Transnational Drug Trafficking Act of 2015, would do is establish penalties for criminals in other countries who traffic in meth precursor chemicals known or having reasonable cause to believe that meth made from those chemicals will then be imported into our country.

A question: Can you explain the role that international traffic in precursor chemicals plays in the distribution of meth here in the United States? Is shutting down this trafficking important? Do you think the legislation I have described will help?

Director LUKAN. I think it certainly is important and can help. Maybe I will use the example of what we have done here in Iowa a number of years ago. Recently, we expanded our own State precursor list, and I think that there has been some—there was some apprehension, and it took a while to work with the legislature to fully inform people on what all the mechanisms were.

I think that are some concerns on the civil liberties side, if you will. I think that some people misunderstand that just because you have camping stove fuel or you might have a certain type of fertilizer for your lawn, there is fear that the State troopers are going to come and knock on your door and you are going to be arrested.

That is far from the truth. I think what we have had to help people understand is you have to prove the intent. It is about putting all the clues together to say this person is doing something outside the norm, and we need to go and have a conversation with them about that.

We think it has also helped drop the number of labs down here in the State because, again, it is a tool, again I think, that law enforcement can use to disrupt the manufacturing. I can only believe it is going to do similar effects on the international level as it has done here at the State level. I think there is a real value in pursuing that, and I think there could be some positive consequences.

Chairman GRASSLEY. Okay. I have another question for you. You also mentioned in your testimony, quote, “the commitment of Federal partners to help stop the flow of meth from Mexico to our State. Obviously, border control is a Federal responsibility.”

Have you taken this issue up directly with this administration? If not, is this something that would be helpful for us to do? I think that they need to know how much meth coming across the border is affecting states like Iowa. Perhaps it makes sense to work jointly on that issue.

Director LUKAN. That does make sense, and probably something that we need to do a better job of, directly communicating with the administration, with the National Office of Drug Control Policy and others, just what type of a problem it is. It is my understanding we do share that where we can. We have talked to members of the administration, but I do not know that we have done it in a formal sense and tried to put anyone on notice, so to speak.

Chairman GRASSLEY. If I could be of any help in that area, let me know. [To Rep. Young.] Would you like to ask more questions?

Representative YOUNG. I have 1 more question.

Chairman GRASSLEY. Okay. Go ahead now.

Representative YOUNG. Thank you, Mr. Chairman. This is really for all witnesses. You talked about the Mexican meth and the purity of it all, the high percentage of the purification of it, and how that obviously is going to make a more powerful drug, obviously.

Can you talk about what is the impact of this purity, this potency, on the illegal drug market, law enforcement, and then treatments with those who are addicted?

Mr. HANSEN. I think I am less worried about the purity. I think people usually dose-adjust. I think there might be some benefit, to be real honest about having pure, because there may be less harmful additives added to it.

I am not sure it is automatically a negative, because I do think most users will adjust to dosing and those kind of things. I guess I do not have any empirical evidence, but I am sure it is absolutely wreaking havoc. I would be interested in some of the other panelists' views on that.

Congressman YOUNG. Thank you.

Lieutenant PAYNE. I would probably tend to agree with what he said, as far as the physical attributes of the people using this higher-grade methamphetamine. I know from the one-pot methods and kind of the home-based meth labs that we were dealing with five, 10 years ago, a lot of the physical characteristics of people were kind of losing teeth, the sunken-in faces, people, quote, "geeking" where they would start scratching at themselves, and paranoia.

I think in the last—dealing with some more of this pure methamphetamine, we are not seeing, that I have seen or some of my investigators, not quite the—like he said, as far as the chemicals not being—it is a more pure form.

It is not using the chemical, just throwing in one thing and get it done. It is more a process here of cleaning it out more and not having those remnants of lithium batteries and muriatic acid and things like that in the type of methamphetamine. I think as far as we have seen, as far as the physical aspects of people and as far as the way they look.

Congressman YOUNG. Okay.

Mr. FEDDERSEN. I guess, reference to purity and the quantities that are coming in—and I do not know if more people have been going to treatment because of the purity or not. Back in the day, when I was on the street, the purity levels were so much lower. I mean, at one time it was 15 percent, 20 to 25 percent. I guess my feeling is if the purity is higher, I do not know if more people are going to become addicted.

I agree with Mr. Hansen, people probably do adjust once they determine the product that is out there. It has been pretty consistently, it has been in the 90's the last several years, as opposed to back in 2005 when it was lower.

The big thing that is different, and take the purity out of it, is the quantities that are coming in that we have never seen before. These individuals are setting up shop not only in Des Moines, but they are picking out rural areas, like a farm near Indianola or a farm outside Fort Dodge, where they store this product, where they try to evade law enforcement.

There is so much product there that when we go out to try to work an investigation, you are not just buying one ounce at a time. There is so much product, they are, like, here, you take 4 ounces and I will give you 4 more. Just pay me for 4; you can pay me back. That was not happening back in the day.

They are actually fronting the drug to us and then for us to pay them back later. They are pushing so much more weight because they have so much of that product. It is so easily made in Mexico and they get it across the borders. There is so much of it.

This is not just Iowa. I met with other law enforcement officers in my position 2 weeks ago. In other States, it is the exact same thing. Same story. We all share our stories about the quantities that are coming in. I have never seen the quantities of meth that is here today. It has never been that prevalent.

Mr. HANSEN. I have heard the same thing, Paul, about the gifting. You are a valuable customer, so I will throw an extra ounce in for you.

Mr. FEDDERSEN. That just spurs that addiction. To give you that much more, even without having to pay for it up front, to have that money.

Congressman YOUNG. Thank you. Director Lukan.

Director LUKAN. I think the one concern that is similar to what Paul has said is any time you have supply, there is going to be demand, unfortunately. That is, from our perspective, all these sides have to work together.

You have to have law enforcement working together with treatment, with prevention, all working together to solve these issues. That is definitely a concern. If you see more being trafficked in, obviously we are going to have related problems to that.

Congressman YOUNG. Any comments, Denise, on this?

Ms. MOORE. I would just agree with what everybody said. I think the meth labs were just much more dangerous for people's health and families that were raised around it. I think there was crazy additives in there that you did not know what you were taking. There is also risk, I guess, dealing with Mexican drugs, if that is where they are coming from.

I would agree with everybody about the [inaudible] and stuff being very dangerous for your health. I do not—I have kind of been out of the scene for a minute, so—

Congressman YOUNG. That is good.

Ms. MOORE. Yes.

[Laughs.]

Congressman YOUNG. Thank you. Mr. Chairman, I am done with my questioning, and I would just like to thank the witnesses for coming by today and informing us and educating us. Thank you.

Chairman GRASSLEY. If you would wait a while, I have got 3 more questions and then I think we will wind down.

I am going to talk to Lieutenant Payne. You noted in your written testimony various laws that were passed, helping decrease the case of clandestine labs, beginning in 2006. Unfortunately, as we have heard, Mexican drug trafficking has strongly stepped in to supply the drugs.

Please tell us how this development has changed the nuts and bolts of your investigations in meth. Do your investigations now require more manpower, more coordination with other law enforcement partners? Or do you now have to rely more on electronic communication evidence, and if so, why? Are there more weapons or violence associated with your investigations now than previously?

Lieutenant PAYNE. Thank you, sir. Yes, back in 2003, 2004, as I was an investigator at the Drug Task Force, as an undercover agent before I became assigned lieutenant there, we dealt with a lot of the stores as far as your larger department stores where they sell the pseudoephedrine. Those times, we would actually speak with those representatives at those stores and actually conduct surveillance inside their businesses and watch people steal methamphetamine—ended up stealing it or else buying it, over the substantial amount that a normal person would a normal prudent person would buy at a store.

When we ended up catching them stealing it, we were able to determine more information through probable cause if they had more than just the pseudoephedrine pills and were able to conduct our investigation that way and corroborate all the evidence and determine these larger labs where we were able to determine where these larger labs were. Through that way, our investigations took us to where we had investigators that would work this information as it developed.

It is to the point where the technology and the resources that we use now are spending so much man—hours on telephones, cell phones that we get cell phone records off of, different types of investigations techniques as far as surveillance, different types of agencies involved with over-the-border.

California agents we have dealt with here, as of recent, the FBI, the DEA. As far as the information we have established here in Iowa, to corroborate our sources over back, over in Mexico or even in California where some of our sources are coming from. In all, yes, our resources and manpower have increased dramatically as far as the type of resources that we need to investigate and in the technology, the way it has changed.

Before, we would sit and do surveillance and arrest the guy on conspiracy to manufacture methamphetamine. It is a much larger chain where you start here and continue to buildup to the larger resources and larger suppliers across the border and in these different states.

You—the mail—the Postal Service, as far as this stuff being transported in, different delivery companies that are—we track the resources with delivery packages that are being shipped in. In co-

operation with other State and local agencies as far as traffic stops and things being—and the people being stopped, and investigation techniques that we are using to corroborate their evidence, and continue our investigations with them.

Chairman GRASSLEY. Okay. Mr. Feddersen, kind of the same question, but in terms of State law enforcement, with the rise of Mexican drug trafficking, have you had to rethink the way you combat the supply side problem? How, if at all, has your strategy changed now that you essentially have transnational organized crime at the heart of what is happening?

Mr. FEDDERSEN. Several things have changed. We talked about the methamphetamine laboratories. In the early 2000s, we used to have with the Iowa Division of Narcotics and the Department of Public Safety, we had an actual meth lab team that traveled around the State. Whenever a meth lab was discovered, we would be contacted. That was 8 to 10 agents, and that took a lot of resources. We worked with local officers and our Federal partners to dismantle those labs.

There was so much manpower and resources put into these meth labs where there really was not very much methamphetamine produced, but the hazards that they caused made it a priority that we take care of that.

Since 2005, after pseudoephedrine was put behind the counter and some other laws were enacted for some of the other ingredients to manufacture meth, to possess them with the intent to manufacture, the labs going down has really gave us an opportunity to focus on the Mexican drug trafficking organizations.

Where it has changed a lot is in law enforcement. Those changes over the last years is there is so much cooperation between our local law enforcement partners and our Federal partners, DEA, ATF and Immigration.

That is what is so important about the local drug task forces, is that really promotes information sharing and collaboration. With the drugs coming in from out of State, it is so important that we work with our local partners to work that case backward, to get to that source in Mexico or California, wherever that source may be, because if we take somebody off here in Iowa, they just replace that person. They send somebody else out, or a group, to distribute that methamphetamine here. Our goal anymore is to work with our Federal partners, DEA and some other ones to backtrack, to do that investigation and go back as far as we can to eliminate that meth to continue to come to Iowa.

Chairman GRASSLEY. Yes. My last question would be to you too. You mentioned about drug-endangered children, or the DEC training, as you call it. You also explained how they are integrated into the multi-jurisdictional DEC teams. Could you explain the training, what types of personnel comprise teams, and how are they deployed in order to make a difference in the lives of children who are exposed to the effects of drugs?

Mr. FEDDERSEN. Yes, law enforcement officers are now trained—when I was a drug enforcement agent on the street, we went through training where we—as a drug enforcement officer, you have got to put a different hat on. When you go into a house, you are looking for evidence, for drug activity.

When you find that evidence, well, the next thing to think about is, okay, is there children in this house? How safe are they here? What do they have access to, and are they being taken care of? You have to turn that hat around and not necessarily be on the law enforcement perspective, but look at it as the human resource perspective.

That is what DEC has done, where that training, they come out and talk to us about that. DEC has eliminated the silos between medical, prosecution, law enforcement, DHS. Because when law enforcement officers go to a house now and they find drugs, we contact DHS and work hand-in-hand with that DHS worker. They come out to the scene and they try to find a place for those children and they go through their process.

I know DHS is also communicating with the medical field, because doctors in the day would just look for physical abuse. Now, they have to look at developmental abuse and making sure these kids are developing at the rate they should. Are they eating on time? Are they going to bed, and things like that. That that person who is addicted to meth is actually caring for that child.

DEC has really come a long ways to eliminate those silos and get everybody communicating on the same page. Once somebody enters that system that we come in contact with them, other entities involved in that are all included and there is a communication ring that takes place.

Chairman GRASSLEY. Okay. Thank you. Before I adjourn—[off mic]. I just asked my staff that if you are interested in following this or have other people follow it, this thing will be posted on the Committee website, the Senate Judiciary Committee website, probably shortly. I do not know whether that is hours or days or—but not very long from now.

I thank our panel for your hard work being here, because I know you have to prepare for this. I thank Congressman Young for coming as well. All of you folks who are here.

I hope that you understand that representing government is a 2-way street. Those of us elected have a responsibility to listen to our constituents, but I hope you also realize you have a responsibility to contact us.

This is a formal way of doing it, but it does not end here. I hope, since representative government's dialog between those of us elected and the people we serve, that you will continue this with us, one way or another.

Remember I said written testimony in the next 10 days would be accepted. Once again, thanks all for coming and the hearing is adjourned. Thank you.

[Whereupon, at 11:32 a.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

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Testimony of

Denise Moore

Field Hearing: The New Era in the Fight Against Methamphetamine in Iowa

October 13, 2015

Des Moines, Iowa

Good morning, I would like to thank you for allowing me to share my experience with you today. My name is Denise Moore and I am a Service Area Coordinator with the Iowa Department of Human Services Parent Partner Program employed by Children & Families of Iowa. Parent Partners are parents who have successfully navigated the child welfare system and reunited with their children and then are trained to assist and support families that are entering the child welfare system. The majority of families that come to the attention of the child welfare system are due to neglect and many of these families are affected by substance abuse. These families are often treated with a one size fits all approach no matter the severity of their addiction, resulting with their children being removed from their care. These interventions are traumatizing for both the children and their families. Parent Partners takes a different approach. Our personal experience and training ensures a trauma-informed approach. Parent Partners have the ability to communicate and empathize with parents building trust and helping resolve the family issues, including achieving sobriety, more quickly.

I am a mother of 7 children who had my children removed due to my methamphetamine use, and from that experience would like to add a different perspective on today's discussion and hopefully shed some light on the desperation and hopelessness of parents affected by methamphetamine (meth) and the children that are left behind. As a service area coordinator of the Parent Partner Program in Iowa, we see families that are being destroyed by meth every day. Statewide the Parent Partner Program is working with over 1,600 parents today with the anticipation of 1,800 by year end.

As a Parent Partner, I understand the experience. The fear, the concern, the panic, but I also understand how to move beyond and achieve the goals that work most importantly for the kids, but also for the community and the best outcomes.

As a country, it makes sense to invest to help and support families at the front end. We need trauma informed care which is just understanding where people are and come from and what they dealt with. It is real and when used well changes the dynamic for families, including those suffering from addiction. We can and should help families like my family move from crisis, to recovery to giving back to our community.

I would like to focus on today's discussion on creating systems that support recovery and allow families to heal together as a unit. To best understand this I would like to share my personal experience. In 2003, I was arrested for conspiracy to deliver meth after living most of my life addicted to multiple substances. I had grown up in a world of substance abuse, sexual abuse, drugs, and domestic violence. It was the only world I knew and it was my norm. Although I wanted something different for my life, I had no idea how to accomplish that. As a result, at the very early age of 12 I started using substances, at first it was casual using but then escalated into selling drugs to finance my habit and to support my family. All

the while my children were subjected to everything that I swore I would never do including drug traffic in their home, seeing me be beaten until I was unrecognizable, and being ashamed and worried about their mother's activities. My children have lost so much by seeing the people they love become incarcerated due to addiction but still they needed me, loved, and accepted me for all that I was.

When I was arrested, my family proceeded to immediately get me out of jail because we knew that the Iowa Department of Human Services (DHS) was coming and that my children would be removed and could be sent to multiple foster homes. DHS did come but an angel came to my door who saw my family as a unit and that my children needed to be together. My mother was allowed to come into my home and I was removed in a matter of minutes. This intervention was critical to the success of not only me but also my children. At this time in child welfare it was unheard of to have a relative placement and for the children to remain in a drug home but this was critical to the success of my family. My children were together, attending the same school, had the same coaches, teachers, and friends. The only thing that was missing was me.

I was sent a case plan in the mail, was homeless, with no education, no driver's license, no money, no job and was completely alone. So I continued to do what I had always known and that was to get high on meth. I continued on that path for approximately a year and a half until I was at termination of parental rights. My case worker lined all my children on the couch including my brand new baby and I had to tell them I was going to lose them forever. My oldest son who had loved me no matter what, had followed me, and believed in me was absolutely crushed because I was choosing drugs over him. I left that meeting and cried for the first time for as long as I could remember for all that I have done to my children, for all the pain from my own childhood, and all that I have lost due to my drug addiction.

I had a meeting with DHS following that meeting and I begged for one more chance. To my surprise they said yes, since all I had ever heard until then is that once your children were removed you never get them back. Looking back now I have seen a parent's rights being terminated for much less than I had done. I vowed to stay clean, starting attending AA meetings, started going to college, got a job and slowly had my children returned to me. I have been clean from drugs for over 10 years.

I was successfully reunited with my children after being away from them for 18 months and my case was closed after 2 years. Since then my children and my family have overcome challenges and withstood many barriers and have become upstanding members of society. My children and I have broken the cycle of addiction and they have gone on to have amazing and wonderful lives. They have healthy relationships, four have graduated high school, they are going to college, buying houses and building families.

Unfortunately, these outcomes and interventions are the exception and not the rule. We need more substance abuse treatment programs that focus on keeping families together. Support also is needed for relatives that step in to take care of our children. My hope is that we will recognize that incarceration and removals leave a trail of destruction for families in their path. I am proof that parents with meth addiction can recover and can create nurturing and stable homes for their children. No one wants to be addicted to meth but most people don't know how to stop.

Through my work with parents and families both across the state and nationally I have seen many children that are growing up without their parents or extended families and have been taken away from

their communities. It is critical that we start looking at these families as a whole and wrap services around them so they heal together and have healthy stable lives that are drug free.

Thank you for your time. I would be happy to take any questions.



STATE OF IOWA

TERRY E. BRANSTAD
GOVERNOR
KIM REYNOLDS
LT. GOVERNOR

OFFICE OF DRUG CONTROL POLICY
STEVEN F. LUKAN, DIRECTOR

Senate Judiciary Committee Hearing

“The New Era is the Fight Against Methamphetamine in Iowa”

Steven F. Lukan
Director Iowa Governor’s Office of Drug Control Policy
Des Moines, IA
13 Oct 2015
10:a.m.

Senator Grassley and staff, thank you for the opportunity to share some thoughts with you today. I would like to begin by thanking you Senator Grassley, for your clear and consistent leadership on anti-drug issues. I believe that all drugs pose a threat to our safety, health and prosperity. Your leadership has been crucial in the fight against meth and other forms of drug abuse, improving the lives of countless Iowans and making our state a better place to work, live and raise a family.

One challenge we face today in the battle against meth is the overall relaxed attitude in the general public that the battle against drug abuse is unwinnable and deserves rethinking. While I understand the concerns of many, let me share one example of how things have gone right. Several years ago I had the opportunity to meet a man who was addicted to meth. The drug crippled his ability to earn a living. He resorted to breaking and entering to support his habit. Distraught and fed up, his wife kicked him out of the home, and he lost all contact with his child. Still, the drug held power over him and he couldn’t see a reason to change.

Finally after being arrested on related charges, he sat in the back of a police car and realized he needed to change. After drying out in jail for several months, he committed to a treatment program and had successful outcomes. Today he holds a full time job as a computer technician, has the love and support of his family once again and enjoys long bike rides on the weekend.

This man is an example that when we have strong laws and law enforcement, coupled with access to quality treatment, we can defeat this and many other drugs.

Another area of success I would like to share is prevention. I am happy to report that Iowa youth soundly reject experimenting with meth. Statistics show that approximately 1% of Iowa youth

have experimented with the drug. While I believe this should be zero, I am still pleased that educators, parents and prevention professionals have worked hard to teach young people about the dangers of this drug. When fully informed on what this and other drugs can do to their bodies, Iowa youth consistently choose to avoid it, greatly increasing their opportunity to lead a full and successful life.

Even so, we must recognize that meth is arguably the most problematic drug in Iowa. It is closely linked with cases of child abuse and neglect, crime, gun violence and incarceration in our state. Iowa ODCP uses federal Byrne Jag funds to partner with multi-jurisdictional drug enforcement task forces across Iowa. These task forces serve as the front line of defense against this powerful drug. In 2014 these task forces seized hundreds of firearms that were involved in meth activity and also referred hundreds of children to the department of human services for care because of neglect and abuse in the home, much of which was linked to meth abuse.

As Byrne-Jag dollars coming to Iowa and other states has decreased, these task forces have had to ask for more support from local governments. Thus far many local governments have stepped in to help support their efforts, but I would like to stress that only so much can be done from the local level. The federal Byrne-Jag dollars have proved to be the crucial glue holding many task forces together. I would ask for continued consideration of the multiplier effect these dollars have in the battle against meth.

Other challenges we face in the battle against meth include legal rulings which make it more challenging for law enforcement to disrupt drug trafficking organizations and confusion in the public about the best approach to defeating drug abuse. I believe it is time to reaffirm our opposition to this and other harmful drugs while at the same time ensuring access to treatment programs that can help people turn their lives around and become productive citizens once again. We also need strong prevention programs to educate and empower young people to make healthy choices for their future.

We should also applaud combined efforts which have helped decrease meth labs in our state from over 1500 to below 200. This is not an insignificant achievement and we have many partners to thank. However, cartel activity that spans Mexico and the United states has helped fill the vacuum, with very pure and powerful forms of meth being found across our state that has been trafficked in from south of the border.

The United States should revisit the issue of meth precursor control agreements with Mexico, as it appears the current system has not been effective in thwarting production of the drug in Mexico. We also need the commitment of federal partners to help stop the flow of this dangerous drug across our nation.

Let me end by again thanking you Senator, for holding this hearing to gain insight into the challenges we face. I believe that strong law enforcement efforts, coupled with quality prevention and treatment programs can work to defeat the menace of meth in our State. I look forward to being a resource to you and our federal partners as we face this challenge together.

Steve Lukan-Director

Terry E. Branstad
Governor
Kim Reynolds
Lt. Governor



Department of Public Safety

Roxann M. Ryan
Commissioner

Senate Committee Judiciary Hearing

“The New Era in the Fight Against Methamphetamine in Iowa”

Paul Feddersen
Assistant Director- Iowa Division of Narcotics Enforcement
Des Moines, IA

October 13, 2015
10:00 a.m.

Thank you for giving me the opportunity to appear before you today on behalf of the State of Iowa and the Iowa Department of Public Safety Division of Narcotics Enforcement to speak about the fight against methamphetamine in Iowa. My name is Paul Feddersen and I currently serve as the Assistant Director of the Iowa Division of Narcotics Enforcement. I have been in law enforcement for 21 years with the majority of it in the field of narcotics investigations.

Domestic manufacturing of methamphetamine in Iowa remains a threat. State and local methamphetamine clandestine laboratory responses up to this date for CY 2015 are approximately 113. This is a significant decline since the peak in 2004 where there were approximately 1,500 annually. In 2005, the Iowa Legislature passed legislation limiting the availability of pseudoephedrine, a key ingredient in the illegal manufacture of methamphetamine. Congress followed shortly after with similar pseudoephedrine purchase restrictions.

Currently the prevalence of methamphetamine labs is the emergence of “one-pot” cooks. These methods generally use less pseudoephedrine and produce methamphetamine in smaller quantities, but are no less dangerous than other production methods. Toxic chemicals, fires, and explosions are significant health and safety risks associated with these methods. The remnants can easily be transported in a vehicle and disposed of in neighborhoods and ditches. Aside from its environmental impact, serious hazards exist for children who come in contact with the waste or families impacted by flash fires from these cooks. The bulk of the labs reported by Iowa law enforcement in recent years have been the “one-pot” labs.

DIVISION OF NARCOTICS ENFORCEMENT • 215 EAST 7TH STREET • DES MOINES, IOWA 50319-0049 • 515-725-6300

Integrity, Fairness, Respect, Honesty, Courage, Compassion, Service

The average cost of a COPS-funded clandestine laboratory clean-up by a Drug Enforcement Agency (DEA) hazardous waste contractor nationwide is now approximately \$2,700 per laboratory. There are hidden costs, as well. For example, state and local law enforcement agencies that seize laboratories must leave personnel on site until the laboratory is cleaned up, often resulting in overtime expenses and lost productivity in other areas.

To assist our local law enforcement partners with the financial burden of the cleanup of clandestine laboratories, in 2014 the Iowa Department of Public Safety Division of Narcotics Enforcement implemented the DEA's Authorized Central Storage or "Container" Program. This program is sponsored by DEA and allows trained/certified law enforcement officers to remove gross contamination (chemicals, solvents, glassware, etc.) from clandestine laboratory sites, safely package the waste pursuant to Federal, state, and local laws and regulations, and transport it to a secure storage container where it is stored until a qualified hazardous waste contractor can remove it for disposal. The DEA provides the storage containers, safety equipment and cleanup materials at no cost to Iowa law enforcement. The Iowa Division of Narcotics Enforcement coordinated this program and has partnered with local law enforcement agencies to strategically place five of these containers on law enforcement controlled properties throughout Iowa. This program is very effective in saving local law enforcement time and money in the cleanup of methamphetamine laboratories.

Although domestic manufacturing of methamphetamine remains a threat, the majority of the methamphetamine is clandestinely produced in Mexico and smuggled across the Southwest Border. Major drug trafficking organizations (DTOs) are undoubtedly the largest contributing factor to the supply of methamphetamine in the state of Iowa. Mexican DTOs are the primary organizational threat to the state of Iowa. They are responsible for the management of sophisticated smuggling, transportation, and distribution networks for methamphetamine in not only Iowa, but throughout the US.

The Iowa Department of Public Safety's Division of Narcotics Enforcement has experienced a significant increase in major cases involving large quantities (multiple kilo purchases/seizures) of purer and more potent methamphetamine smuggled into Iowa from Mexico and other states. The Division of Narcotics Enforcement is on course this year to seize double the amount of methamphetamine that was seized last year. The most recent report from the Iowa Division of Criminal Investigations Crime Lab reports the average purity level of methamphetamine confiscated in Iowa to be 98%. That compares with an average purity level ranging from 14% to 40% ten years ago.

With the large quantities of high purity methamphetamine flooding Iowa there has been a significant decrease in the price of methamphetamine. In 2009 one pound of methamphetamine could cost anywhere from \$27,000 to \$32,000. Today the price for one pound of methamphetamine is \$10,000 to \$14,000.

The state of Iowa sits in the heart of the Midwest crisscrossed by Interstates 80 and 35, which connect the east and west coastal regions of the United States and provides an international corridor for drug importation and distribution for DTOs. A recent example of

this is a Trooper with the Iowa State Patrol was conducting traffic enforcement on the interstate system and recovered approximately 37 pounds of methamphetamine.

The Division of Narcotics Enforcement and the local drug task forces in Iowa have also identified drug endangered children as a priority. Officers have received Drug Endangered Children (DEC) training, and most task forces have implemented formal multijurisdictional DEC teams. The DEC teams incorporate the principles of substance abuse prevention, intervention, treatment, child protection, prosecution, and drug enforcement to protect children from drug users, dealers and manufacturers. The DEC program, coordinated by the Office of Drug Control Policy, features law enforcement officers working side-by-side with DHS caseworkers, prosecutors, court officials and health care providers toward a common goal: protecting children. The DEC model is being adopted by Iowa communities, helping interested entities and stakeholders join together as a safety net for children and a way of encouraging custodial parents to deal with their addictions so that families can be reunited in healthy ways.

The Division of Narcotics Enforcement actively promotes joint cooperative investigations that often cross jurisdictional lines. Experience clearly demonstrates combining the knowledge, expertise, and resources of many agencies and jurisdictions are the most effective and cost-efficient methods of conducting large-scale investigations of major traffickers.

TRI-COUNTY DRUG ENFORCEMENT TASK FORCE

715 MULBERRY ST WATERLOO, IOWA

BLACK HAWK AND BREMER COUNTIES

Senate Committee Judiciary Hearing

“The New Era in the Fight Against Methamphetamine in Iowa”

Corbin Payne
Lieutenant- Tri-County Drug Enforcement Task Force
Waterloo, Iowa

October 13th, 2015
10:00 a.m.

Thank you for giving me this invitation and the opportunity to appear before you today to speak about the every changing fight against methamphetamine. My name is Corbin Payne I am Lieutenant with the Waterloo Police Department currently assigned to the Tri-County Drug Enforcement Task Force in Waterloo.

Just a little background about myself I was born and raised in Waterloo and received a Bachelor of Arts degree from Wartburg College. I began my Law Enforcement career with the Oelwein Police Department in 1995 and a year later was hired by the Waterloo Police Department.

I have been a member of the Waterloo Police Department for 20 years. I have worked as a patrol officer for several years and then assigned to the Drug Crime Unit (DCU) which was a uniformed drug enforcement unit that focused on street level narcotic dealers in the Waterloo area. After several years of working the DCU, I was assigned to the Tri-County Drug Enforcement Task Force as an investigator. This assignment involved working long-term narcotics cases and undercover operations.

I worked this assignment for approximately 5 years then promoted to Patrol Sergeant and shortly after was assigned to the Citizens Response Unit (CRU) that focused on problem areas in Waterloo. Spending approximately 3 years as the CRU supervisor, I was promoted to Lieutenant and assigned to the Patrol Division as the Watch Commander. After fulfilling these duties for 4 years, I was assigned to the Tri-County Drug Enforcement Task Force where he is currently responsible for day to day operations and supervision of the narcotic investigators and overseeing grant funding for the Task Force.

I have had the honor to be assigned to various duty assignments while employed with the Waterloo Police Department.

Which include:

- Supervisor – High Risk Tactical Unit (TAC TEAM)
- Dignitary Protection Supervisor
- Bike Patrol
- Defensive Driving Instructor

I am also honored to be a graduate of the FBI National Academy. This academy included a 13 week Senior Law Enforcement Administrator training course at the FBI Academy in Quantico, Virginia. This academy included 266 ranking law enforcement officials from around the world.

History of the Tri-County Drug Enforcement Task Force. (TCDETF)

The Tri-County Drug Enforcement Task Force was developed in 1991 to combat illegal drug trafficking in Black Hawk and Bremer counties. The Task Force is federally funded by the Byrne-Justice Assistance Grant Program since its inception.

Task Force Agency Involvement and coverage area.

The assigned areas of responsibility for the Task Force are comprised of a lightly populated rural area within the densely populated urban areas. Contained within a geographical area of approximately 200 square miles and a population base of nearly 170,000 with a diverse mixture of ethnic, cultural and socio-economic backgrounds. These areas include the cities of Waterloo, Cedar Falls and supported cities within the Black Hawk and Bremer County that also include the following cities of Waverly, Hudson, Evansdale, LaPorte City and also the University of Northern Iowa.

The Task Force is comprised of full-time investigators and supervisory staff from the Waterloo Police Department, Investigator from the Cedar Falls and Black Hawk County Sheriff's Office and an Analyst from the Iowa National Guard. Task Force investigators maintain a close working relationship the Iowa Division on Narcotics Enforcement (DNE), Department of Corrections and a continuous dialogue with the Department of Human Services to better track child endangerment and treatment as it relates to illegal drug offenses.

Investigators within the Task Force maintain a constant working relationship with several Federal Law Enforcement agencies, including ATF, ICE, DEA, US Postal Inspectors, US Attorney's Office and in particular the FBI, due to the fact the FBI maintains a regional office in Waterloo that provides great resources and support in many of the Federal drug cases that the Task Force investigates.

Duties and operations of the Tri County Drug Enforcement Task Force.

The Investigators with the Tri-County Drug Enforcement Task Force investigate multiple areas of major narcotics trafficking and manufacturing at both the State and Federal levels. These areas include but are not limited to the illegal sale and distribution of methamphetamine, crack-cocaine, cocaine, high-grade marijuana, heroin, hash-oil, prescription drugs and the investigation of firearms commonly associated with the distribution of illegal narcotics.

Because of the numerous types of drug cases being investigated, considerable resources are needed to investigate, apprehend and prosecute the subjects involved. Different law enforcement techniques, strategies and operations are required as the type of drugs being investigated change.

Through the use of combined resources and technology, the Task Force continues to advance our success rate in crippling and destroying criminal drug distribution organizations and networks. The destruction of these criminal organizations successfully disrupts the importation of significant amounts of methamphetamine (ICE), high-grade marijuana, crack cocaine and cocaine into our area. The shared intelligence, investigations and partnerships continue to reap benefits in our efforts against these organized drug distribution networks.

Methamphetamine in Iowa

Over the last ten years the method of methamphetamine manufacture and distribution has changed significantly in our area. Home-based methamphetamine labs have experienced a drastic decline in recent years due in part to the enacted state statues limiting the sale of precursors specifically pseudoephedrine, but labs do still present a significant threat to local communities when they are discovered.

When the decline of the larger home-based labs began to decrease, the more transportable and concealable One-Pot methods of methamphetamine began to rise. This is a more convenient way of making meth quicker and does not require clandestine lab type items to make the meth. This type of meth cook results in a lower yield of meth with a lower purity level. These One-Pot cooks also became more of a hazard to the public because of the way the chemically laced vessels were being discarded. Due to fact these are transportable they are often times discarded in public areas such as parks and road side ditches.

Tri-County Drug Enforcement Methamphetamine Labs Stats:

2003- 112 labs submitted
2004- 117 labs submitted
2005- 74 labs submitted Pseudoephedrine Control Acts enacted.
2006- 30 labs submitted
2007-2011 The labs submitted remained about the same.
2012- 72 labs submitted, majority of labs submitted were One-Pot labs.
2013- 31 labs submitted majority of labs submitted were One-Pot labs
2014- 8 labs submitted majority of labs submitted were One-Pot labs

The Increase of (ICE) Methamphetamine distribution

Methamphetamine- (ICE) Methamphetamine continues to be one of the largest problem drugs in our area in the recent years. The Task Force has been very active in investigating large Mexican drug trafficking organizations. These organizations have been a major threat not only to our area, but in Iowa and the Midwest. During the investigation we have determined that massive amounts of (ICE) methamphetamine has been either transported by vehicle or shipped to Black Hawk County and surrounding areas from organizations in Mexico and California. During investigations from 2011 to present, the Task Force has seized over 60 pounds of ICE with a street value of nearly 4 Million Dollars. The Task Force is currently working these investigations along with a number of agencies, including the DNE, HSI, FBI and the U.S. Attorney's Office

During our investigation we have learned through the State Crime Lab that the test results coming back from this type of methamphetamine is testing at a rate of nearly 97-98% purity level, which is a substantial difference between the "Home-Based labs" which labs results of a 65-75% methamphetamine purity level.

Prices constant with the sale and distribution of Methamphetamine in our area are as follows

- Ice- Methamphetamine sells for about \$120-\$150 a gram
- Home-based or One-Pot methamphetamine sells for about \$80-\$120 a gram.

In conclusion, as I have indicated clandestine labs and one-pot methods still pose a significant threat not only to the investigators working these cases, but also to the citizens in the community that may come into contact with them. Toxic chemicals, fires and explosions remain a constant concern for the safety of the community and anyone exposed to these types of situations. It is very evident that the importation of ICE methamphetamine into Iowa has become a major issue not only for law enforcement but to the community as a whole. The large amounts of money being made, weapons being seized along with the huge supply and demand of this highly addictive drug, requires that we continue to fund these efforts and remain vigilant.

Thank you for your time and the opportunity to present this information.

Lt. Corbin Payne
Tri-County Drug Enforcement Task Force.

**Testimony to the Judiciary Committee
Senator Charles Grassley**

Jay Hansen

Executive Director, Prairie Ridge Integrated Behavioral Healthcare

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Jay Hansen is currently the Executive Director of Prairie Ridge Integrated Behavioral Healthcare in Mason City, Iowa. He began with the organization in 1974 after graduating from the University of Northern Iowa with a degree in Social Work. Mr. Hansen was appointed the Executive Director in 1980 and has served in that role to the present. He has held various clinical and administrative roles over the years and has had an interest in quality improvement efforts on a state-wide and national level. In 2006, Mr. Hansen was the Executive Sponsor for Prairie Ridge in a national effort to improve substance use disorder care through the Robert Wood Johnson Foundation and the University of Wisconsin. He has served as Past President of the Iowa Behavioral Health Association and has recently been reappointed by Governor Branstad to his third term on the State Board of Health. He also chairs the Substance Abuse and Problem Gambling Committee for the Board. Jay also has served on numerous task forces and commission and has provided numerous trainings and presentations related to substance use disorders on a local, state and national level. He was published in the National Institute on Drug Abuse journal, Science, Practice and Perspective in April of 2007, discussing strategies for treating methamphetamine abuse.

Over the past 15 years we have gained a much clearer understanding of addiction and the relationship to the brain. Dr. Nora Volkow, at the National Institute of Drug Abuse and others have shown through brain scans and research, how drugs act on the neurotransmitters in the pleasure center of the brain.

The reward, or pleasure center of the brain have, been responsible for our survival over the years. It rewards us when we eat/drink, procreate, and when we affiliate with others. Those rewards have encouraged human kind to do the things that help us survive and grow. Unfortunately, those addicted to drugs have added another layer to those basic reward pathways-addiction.

The reason we have drug problems in our society are due to the fact that drugs work so well-at least for the short term. The better they make us feel, the more susceptible we are for repeated use. Meth is likely the granddaddy of reward resulting in a massive release of dopamine in the brain resulting in euphoric state unlike anything they have ever experience before. For example, in lab experiments done on animals, sex causes dopamine to levels to jump from 100 to 200 units, and cocaine causes them to spike to 350 units. With methamphetamine you get a release from the base level to 1,250 units, something that is about 12 times greater than pleasurable activities such as eating.

Those with meth addictions report that the first time they use meth, it was an incredibly positive and rewarding experience. They will continue to chase the first time high into the future- never finding it again. The human body will attempt to maintain homeostasis from the time of first use. With massive amounts of dopamine released into the reward pathway, the brains says whoa, this is too much of a good thing. The brain will begin to reduce the absorption and production of dopamine as a way to protect itself leaving the user without normal levels of dopamine which leads to eventual craving and drug seeking. Over time, the user seeks meth to feel normal not high. This begins the cycle of addiction that is very hard to break.

Addiction is difficult to understand. It seems so obvious that those addicted should see the problems that their use is causing and make the decision to quit before serious problems occur. Two of the best definitions of addiction that I have found are: continued use in spite of negative consequences, and, an irresistible urge to perform an irrational act. Both highlight the fight between the addicted brain and logical decision making based upon reason and judgement. Imagine being 200 feet below the water's surface, running out of air. You know that breathing will cause you to drown-yet you breathe because you brain is saying you need this to live. You know it is irrational to do so, yet the urge to do so is irresistible. When the areas of the pleasure center are not satiated, great desire or craving is created to satiate them. And that is the battle of addiction, a brain screaming for drugs. Drugs that you know will harm you, and you breathe in spite of that knowledge.

That is what substance use disorder treatment is about, helping persons understand the brain disease and bolstering the part of the brain that can mediate the urges and cravings. Treatment of methamphetamine starts by assessing the physical and emotional

consequences of the addiction. The early phase of treatment is very important attempting engage the person and create a sense of hope. Providing sleep, good nutrition and supports are all crucial at this stage. As individuals begin to stabilize, cognitive behavioral skill building and relapse prevention can begin along with urine screens for accountability. Family support is very important to provide both accountability and support for change. Attention to the environment they will return to and the changes that need to happen to avoid triggers and urges in their daily life. They will return to a life that will be a war between the pleasure center of the brain and their new logical brain that can fend off cravings and urges. To return to the breathing analogy, treatment can provide them with planning and skills so that when they are 200 feet below water, they will have put in place skills and thinking that will save their life.

There have been various accounts that methamphetamine treatment is not successful. In Iowa, independent outcomes have supported methamphetamine treatment to be as successful as other drugs of abuse. More than half of those seeking treatment in Iowa report very positive outcomes including abstinence, fewer hospitalizations, increased employment and income and greatly reduced legal problems as reported by the University of Iowa Research Consortium.

Methamphetamine is a powerful, highly addictive stimulant that effects the central nervous system. Also known as meth, chalk, ice, and crystal, among other terms, it takes the form of a white, odorless, bitter tasting crystalline powder that easily dissolves in water or alcohol.

Methamphetamine was developed early in the 20th century from its parent drug, amphetamine, and was used originally in nasal decongestants and bronchial inhalers. Like amphetamine, methamphetamine causes increased activity and talkativeness, decreased appetite, and a pleasurable sense of well-being or euphoria. However, methamphetamine differs from amphetamine in that, in comparable doses, much greater amounts make its way into the brain, making it a more potent stimulant. It also has a longer lasting and more harmful effects on the central nervous system.

Methamphetamine has been classified by the U.S. Drug Enforcement Administration as a schedule II stimulant, which makes it legally available only through a non-refillable prescription. Medically it may be indicated for the treatment of Attention Deficit Hyper-Activity Disorder (ADHD) and as a short term component of weight loss treatment.

According to a 2012 National Survey on Drug Use and Health (NSDUH), approximately 1.2 million people (0.4% of the population) reported using methamphetamine in the past year, and 440,000 (0.2%) reported using it the past month. This represents a decrease from previous years; in 2006 731,000 (0.3%) reported past month use. In 2012, there were 133,000 new users of methamphetamine age 12 or older – the same as the previous year but continuing a general down-ward trend across the past decade. The average age of new methamphetamine users in 2012 was 19.7 years old.

The 2012 Monitoring the Future (MFT) survey of adolescent drug use and attitudes reported that about 1% of 8th, 10th, and 12th graders had used methamphetamine within the past year. This data indicates that 10th and 12th graders are using methamphetamine less than they did five years ago, but that use by 8th graders has not dropped significantly in that time.

According to the Drug Abuse Warning Network (DAWN), which collects information on drug related episodes from hospital emergency departments throughout the nation, methamphetamine accounted for 103,000 emergency department visits in 2011; it was the fourth most mentioned illicit drugs in emergency department visits following cocaine, marijuana, and heroine. While still high, the number represents a decrease from the 132,576 emergency department visits for methamphetamine abuse measured in 2004.

The Treatment Episode Data Set (TEDS) provides information on admissions to substance use disorder treatment facilities that are licensed or certified by state substance use disorder agencies. According to the TEDS data, nationwide treatment for admissions for methamphetamine abuse dropped from 8.1% in 2005 to 5.6% in 2011. The majority of primary methamphetamine admissions were male (53%), and two-thirds (68%) were non-Hispanic whites.

Prairie Ridge Integrated Behavioral Healthcare in North Central Iowa substance use disorder treatment facility reported the following admissions from year 2007-2015:

YEAR	% of Methamphetamine Admits
2007	19%
2008	15%
2009	17%
2010	18%
2011	14%
2012	17%
2013	21%
2014	23%

While national trends are showing declines, methamphetamine abuse continues to exhibit regional variability. The strongest affects are felt in the west and parts of the mid-west, according to the National Institute on Drug Abuses (NIDA) and Community Epidemiology Work Patterns of Drug Abuse across the United States.

Methamphetamine comes in several forms and can be smoked, inhaled (snorted), injected, anally, or orally ingested. The preferred method of abusing the drug varies by geographical region and has changed over time. Smoking methamphetamine is currently the most common way of ingesting it.

Smoking or injecting methamphetamine puts the drug very quickly into the blood stream and brain, causing an immediate, intense "rush" and amplifying the drug's addiction potential and adverse health consequences. The rush or "flash" lasts only a few minutes and is described as extremely pleasurable. Snorting or oral ingestion produces euphoria/a high, but not an intense rush. Snorting produces effects within three to five minutes and oral ingestion produces effects within 15 to 20 minutes.

As with many stimulants, methamphetamine is most often abused in a "binge and crash" pattern. Because the pleasurable effects of methamphetamine disappear even before the drug concentration in the blood falls significantly, users try to maintain a high by taking more of the drug.

Most of the methamphetamine used in this country is manufactured in "super labs" here or in Mexico. The drug is also easily made in small clandestine laboratories, with relatively inexpensive over the counter ingredients such as pseudoephedrine, a common ingredient in cold medications. The curb production of methamphetamine, Congress passed the Combat Methamphetamine Epidemic Act in 2005, which requires that pharmacies and other retail stores keeps logs of purchases of products containing pseudoephedrine and limits made pseudoephedrine available only with a prescription. Mexico has also tightened its restrictions on this and other methamphetamine precursory chemicals.

Manufacturers have adapted to these restrictions via small-or large-scale smurfing operations: obtaining pseudoephedrine from multiple sources, below the legal thresholds, using multiple false identifications. Manufacturers in Mexico are also increasingly using a different production process (called P2P, from the precursor chemical phenyl-2-propanone) that does not require pseudoephedrine.

Methamphetamine production also involves a number of other easily obtained chemicals that are hazardous such as acetone, anhydrous ammonia (fertilizer), ether, red phosphorus, and lithium. Toxicity from these chemicals can remain in the environment around a methamphetamine production lab long after the lab has been shut down, causing a wide range of damaging effects to health.

The methamphetamine molecule is structurally similar to amphetamine and the neurotransmitter dopamine, a brain chemical that plays an important role in the regulation of reward, but it is quite different from cocaine. Although these stimulants have similar behavioral and physiological effects, there are some major differences in the basic mechanisms of how they work.

In contrast to cocaine, which is quickly removed from and almost completely metabolized in the body, methamphetamine has a much longer duration of action, and a larger percentage of the drug remains unchanged in the body. Methamphetamine, therefore, remains in the brain longer, which ultimately leads to prolonged stimulant effects. Although both methamphetamine and cocaine increase levels of dopamine, administration of methamphetamine in animal studies leads to much higher levels of dopamine, because nerve cells respond differently to the two drugs. Cocaine prolongs dopamine actions in the brain by blocking the reabsorption (re-uptake) of the neurotransmitter by signaling nerve cells. At low doses, methamphetamine also blocks the reuptake of dopamine, but it also increases the release of dopamine – leading to much higher concentrations in the synapse (the gap between the neurons), which can be toxic to the nerve terminals.

As a powerful stimulant, methamphetamine, even in small doses, can increase wakefulness and physical activity and decreases appetite. Methamphetamine can also cause a variety of cardiovascular problems, including rapid heart rate, irregular heartbeat, and increased blood pressure. Hypothermia (elevated body temperature) and convulsions may occur with methamphetamine over-dose, and if not treated immediately can result in death.

Most of the pleasurable effects of methamphetamine are believed to be the result of release of very high levels of the neurotransmitter dopamine. Dopamine is involved in motivation and the experience of pleasure and motor function. It is also a common mechanism of action for most drugs of abuse. This elevated release of dopamine produced by methamphetamine is also thought to contribute to the drugs' deleterious effects on the nerve terminals in the brain. Short term effects may include increased

attention and decreased fatigue, increased activity and wakefulness, decreased appetite, euphoria and rush, increased respiration, rapid/irregular heartbeat, and hyperthermia.

Long term methamphetamine abuses has many negative consequences, including addiction. Addiction is a chronic, relapsing disease, characterized by compulsive drug seeking and use and accompanied by functional and molecular changes in the brain.

As in the case with many drugs, tolerance to methamphetamine's pleasurable effects develops when it is taken repeatedly. Abusers often need to take higher doses of the drug, taking it more frequently, or change how they take it in an effort to get the desired effect. Chronic methamphetamine abusers may develop difficulty feeling any pleasure other than that provided by the drug, fueling further abuse. Withdrawal from methamphetamine occurs when a chronic abuser stops taking the drug; symptoms of withdrawal include depression, anxiety, fatigue, and an intense craving for the drug.

In addition to being addicted to methamphetamine, chronic abusers may exhibit symptoms that can include significant anxiety, confusion, insomnia, mood disturbances, and violent behavior. They also may display a number of psychotic features including paranoia, visual and auditory hallucinations and delusions. Psychotic symptoms can sometimes last for months or years after a person has quit abusing methamphetamine and stress has been showed to precipitate spontaneous reoccurrence of methamphetamine psychosis and formally psychotic methamphetamine abusers.

These and other problems conduct significant changes in the brain caused by abuse of methamphetamine: neuroimaging studies have demonstrated alterations in the activity of the dopamine system that are associated with reduced motor speed and impaired verbal learning. Studies in the chronic methamphetamine abusers have also revealed several structural and function changes in the areas of the brain associated with emotion and memory, which may account for many of the emotional and cognitive problems observed in chronic methamphetamine abusers.

Methamphetamine abuse has also been shown to have negative effects on non-neural brain cells called microglia. These cells support brain health by defending the brain against infectious agents and removing damaged neurons. Too much activity of the microglia cells, however, can assault healthy neurons. A study using brain imaging found more than double the levels of microglia cells in former methamphetamine abusers compared to people with no history of methamphetamine abuse – which could explain some of the neuro toxic effects of methamphetamine.

Some of the neural biological effects of chronic methamphetamine abuse appear to be at least partial reversible. In the aforementioned study, abstinence from methamphetamine resulted in less excess microglial activation over time, and abusers who had remained methamphetamine free for two years exhibited microglial activation levels similar to the study's control subjects.

In addition to the neurological and behavioral consequences of methamphetamine abuse, long term users also suffer physical effects including weight loss, severe tooth decay and tooth loss, and skin sores.

The most effective treatments for methamphetamine addiction are behavioral therapies, such as cognitive-behavioral and contingency-management interventions. For example, the Matrix Model, a 16 week comprehensive behavioral treatment approach that combines behavioral therapy, family education, individual counseling, twelve step support, drug testing, and encouragement from non-drug related activities has been shown to be effective in reducing methamphetamine abuse.

Although medications have proven effective in treating some substance use disorders, there are currently no medications that counteract the specific effects of methamphetamine or that prolong abstinence from and reduce the abuse of methamphetamine by individuals addicted to the drug.

One Program's Transition to Research-Based Strategies for Treating Methamphetamine Abuse

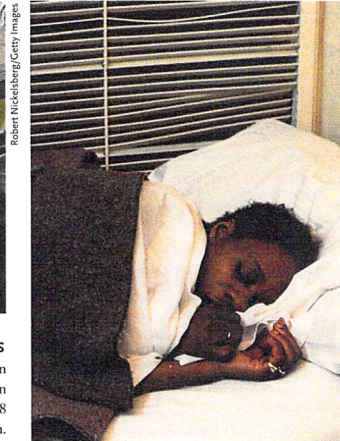
Prairie Ridge Addiction Treatment Services turned to SAMHSA's Treatment Improvement Protocol (TIP) 33, "Treatment for Stimulant Use Disorders," to try to establish more effective practices for their fast-growing population of methamphetamine-addicted clients. Six years later, Prairie Ridge's executive director says that adopting the TIP's client-based treatment philosophy has enhanced the program's accessibility and results, not only for stimulant-abusing clients, but others as well. In this article he recounts how the TIP contents meshed with Prairie Ridge's preexisting treatment philosophy and practices; what they adopted and what they adapted from the TIP and why; counselors' responses during the transition; and outstanding issues.

Jay M. Hansen
Prairie Ridge Addiction Treatment Services
Mason City, Iowa



In many ways, Prairie Ridge Addiction Treatment Services was well positioned to make good use of Treatment Improvement Protocol (TIP) 33, "Treatment for Stimulant Use Disorders," when the Substance Abuse and Mental Health Services Administration (SAMHSA) published it in 1999. The number of clients coming to us for help with methamphetamine abuse had been rising steeply for a year, and our staff were eager for information on effective treatments. Organizationally, we were beginning to focus on implementing evidence-based practices, which is a primary rationale of the TIP. As well, we were moving toward a client-centered approach to treatment, which accords with the overall thrust of the TIP. For example, we were working to implement Dr. Carlo DiClemente's Transtheoretical Model of Change (Prochaska and DiClemente, 1984), which focuses on engaging clients and recognizing their individual needs, while also recognizing that drug abuse treatment is a gradual process with distinct stages. We had begun accepting clients regardless of their stage of recovery, using motivational interviewing techniques, and trying to "roll with resistance" rather than pushing clients beyond their capabilities.

Our prior decision to move in these directions increased our receptivity to the TIP and facilitated implementation. We are convinced that adopting the evidence-based recommendations of the TIP has enhanced our treatment of methamphetamine abuse, which also is now better attuned to the drug's neurobiological effects. Nevertheless, the process was challenging, and structural factors combined with the nature of the TIP have limited our ability to implement the protocol systematically or to confirm its efficacy in our setting scientifically.



We focus on the fact that we have another opportunity to help clients after a relapse

WHAT WE ADOPTED: CONFIRMED PRACTICES

Prairie Ridge's client population is 93.4 percent Caucasian and 61.3 percent male; 47.7 percent of the population is referred by the criminal justice system, and 84.8 percent report an income of less than \$1,000 per month. Although Prairie Ridge had limited experience treating methamphetamine abuse before TIP 33, we had treated other stimulant abuse, mainly cocaine, for many years. We had already implemented, in one form or another, several of the protocols contained in the TIP. The TIP confirmed the validity of these existing practices and also encouraged us to focus additional attention on some of them. We found we could use the TIP without making wholesale changes to our organization and treatment methods, by simply reorganizing existing staff and services.

Relapse

It is rare for clients to go from active, full-blown stimulant addiction to complete abstinence. Rather, most clients go through a phase during which there are days without substance use and days with substance use (TIP 33, chapter 4).

Like many substance abuse programs, Prairie Ridge historically viewed relapse as a client's lack of commitment to abstinence, but in 1999 we began to recognize relapse as an episode in a chronic illness and started adjusting our policies accordingly. Instead of categorically denying clients reentry after a relapse, we might suggest they try a different treatment environment or prove their motivation. TIP 33, which suggests that "slips" should be regarded not as failures, but as oppor-

tunities to reevaluate the treatment plan, spurred us to go further in this direction. We now focus on the fact that clients come back after a relapse, and we have another opportunity to help them. This adjustment in attitude, which we extend to relapse-related behaviors such as missed appointments and resistance, especially during early treatment phases, has significantly increased our retention of clients.

Prairie Ridge staff were especially impressed with the sections of the TIP on relapse prevention, which promotes a focus on identifying the factors that led to the relapse and developing strategies for avoiding them in the future (such as cue avoidance; participation in new, positive activities; and development of coping and stress management skills). Counselors found the TIP's list of specific cues and triggers and corresponding avoidance strategies very helpful.

Of course, neither Prairie Ridge nor TIP 33 recommends that relapses continue indefinitely. Methamphetamine treatment entails working with clients as they struggle with cravings and, in many cases, relapse, but the only successful outcome is sustained abstinence.

Urinalysis Screens

Stimulant-dependent clients in outpatient programs need structure that provides support for engaging in healthy

Robert Nickelberg/Getty Images

Wiviane Moss/CORBIS

behaviors. Urine testing is part of that structure. It should not be presented or used primarily as an investigative tool or to test the honesty of clients. Rather, it should be used and presented as a means of support for initiating and maintaining sobriety (TIP 33, chapter 4).

Prairie Ridge has always conducted urinalysis (UA) screens, but TIP 33 broadened our understanding of their importance. Following its advice, we have increased the frequency of screening and now aim to test clients twice a week during the early stages of engagement. Increased screening has not raised the rate of positive findings: More than 90 percent of results are negative.

The staff present the screens as a way for clients to document their abstinence, because many clients contend with people's mistrust and disbelief in their recovery progress. The UAs are a key indicator of success for clients who are answerable to the child welfare and corrections systems, or other authorities with which we routinely share results. We reduce screening frequency as clients progress through treatment, but we warn clients that they may be asked to submit a sample at any time.

WHAT WE ADOPTED: NEW PRACTICES

TIP 33 contains a wealth of information and suggestions related to methamphetamine's effects on the brain and their implications for treating clients. It encouraged us to confront difficult issues that we were aware of, but had not yet fully engaged, most particularly the extreme exhaustion clients feel immediately after entering treatment and the sexual side effects of methamphetamine abuse and withdrawal.

A Period of Rest

The initial period of stimulant abstinence is characterized by symptoms of depression, difficulty concentrating, poor memory, fatigue, craving, and paranoia. The duration of these symptoms varies; however... they typically last 10 to 15 days for methamphetamine users (TIP 33, chapter 4).

The TIP changed our thinking on new methamphetamine clients who participated weakly or asked to be excused from treatment sessions. It stresses that they may not be unmotivated, as the old-school philosophy assumed, but too exhausted and debilitated by the drug's neurobiological effects to keep up. Accordingly, we scrapped our practice of imposing strict treatment schedules on clients immediately after their arrival. Instead, we now direct our initial efforts toward clients'

TREATMENT IMPROVEMENT PROTOCOLS: EVIDENCE-BASED INNOVATION

The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes TIPs to provide clinicians with best practice guidelines for the treatment of substance use disorders. Topics are selected in consultation with substance abuse experts in a wide variety of fields, and each TIP is composed by a non-government-affiliated consensus panel. TIPs are reviewed by a large group of experts before a final version is made available online and in print.

TIPs include a mixture of evidence-based recommendations and "front line" information that has not yet been empirically validated, but has shown signs of success in real-world treatment environments. In their executive summary of TIP 33, the authors state that "The Consensus Panel that developed this TIP tried to emphasize those treatment techniques and principles that have been established with empirical support. However, because the science of treating stimulant use disorders is barely a decade old, the Panel also reviewed and synthesized a set of techniques and principles developed and supported by leading addiction specialists, but with less empirical support." TIP 33, like all other TIPs, clearly distinguishes those treatment approaches that are empirically supported from those that are currently based on consensus opinion.

physical well-being, ensuring that they are well-fed and well-rested rather than expecting them to be awake first thing in the morning and attend group meetings. We have found that clients do not always need the full 10 to 15 days suggested by the TIP before engaging in treatment; in most cases, a few days of downtime monitored by our residential program nurse is sufficient. The implicit message this new approach sends our clients is not simply that they will benefit from a period of recuperation, but also that we understand their needs and state of mind.

We extend this policy to clients who are in jail. Instead of transferring them to our treatment center immediately, we send a counselor to the jail to assess the client's needs; if a short incarceration will not be detrimental to the client's health, we ask the county attorney to keep him or her for a week or two. Of course, it is unfortunate that we have to use the prison system in this way, but our counselors have noted that clients are mentally and physically readier to participate and face the demands of the treatment program if they are allowed this initial period of rest. We are convinced that they achieve better outcomes, too.

Sexual Issues

Stimulant-dependent clients can have tremendous concerns and anxieties about the compulsive sexual behaviors they

We direct our initial efforts toward clients' physical well-being

TIP WORKSHEETS

TIP 33 features 44 worksheets dealing with a wide variety of topics, from identifying signs of stress and managing anger to listing positive recreational and exercise activities. Prairie Ridge counselors found these to be very useful tools for facilitating engagement, as they provided a framework for confronting issues that every client encounters and discussed easily accessible strategies for tackling common problems.

Worksheet #1, which asks clients to plan all of their activities for the day, from 7 a.m. to 11 p.m., may seem overly simplistic, but we found this type of hour-by-hour schedule to be very helpful in ensuring that clients avoid risky behaviors and situations. Similarly, worksheet #2, "Identifying External Cues and Triggers," lays out a simple method of encouraging clients to recognize the people, places, events, and objects that are strongly associated with methamphetamine abuse. This worksheet, used in conjunction with worksheet #4, provides clients with an action plan for times when they are confronted with cues and triggers, allowing them to leave a counseling session with a set of easy-to-remember strategies that they can implement immediately.

engage in while using stimulants Client fears should be addressed, such as the fear that sex without drugs will be boring or impossible (TIP 33, chapter 4).

Unless sexual issues are addressed in treatment, they can pose barriers to engagement and retention

Our methamphetamine-abusing clients frequently report that the drug enhances sex and abstinence spoils it. TIP 33 persuaded us that failing to address sexual feelings and experiences in treatment can compromise some clients' chances for recovery. Memories of the powerful sexual urges and sensations associated with the drug can be strong relapse triggers, as can a return to previous relationships or liaisons. The TIP called our attention, as well, to the link between methamphetamine and compulsive sexual activities that clients may look back upon with shame and confusion, such as promiscuous sex, behaviors known to increase the risk of AIDS, compulsive masturbation and pornography viewing, and homosexual behavior by heterosexual individuals. Unless such experiences and clients' reactions to them are addressed in treatment, they can pose barriers to engagement and retention. Although there is always discomfort in talking with clients about sexual issues, the TIP provides counselors with science-based information that allows them to begin questioning clients and helping them work through their issues.

Methamphetamine and the Brain

Of all the changes TIP 33 prompted us to make, the most overarching and consequential was to adopt as a central basis for our activities the protocol's extensive

information on how stimulants affect the nervous system and change feelings, emotions, and behavior. Chapter 2 describes the fundamentals of the nervous system, the role dopamine plays in the brain's reward system, and the way that harmful behaviors, through positive reinforcement, can become repetitive. It also catalogues the deleterious psychological effects of methamphetamine abuse and withdrawal.

This information comprised the conceptual basis for our revised policies of giving clients rest, addressing sexual concerns, and rolling with resistance rather than confronting it. The information persuaded some counselors to cooperate with the new policies even though their previous experience and instincts argued that such "leniency" was inappropriate. Several staff commented as we began to implement the protocol that clients were not showing any real signs of progress, yet counselors were being asked to continue to devote valuable hours and resources to their treatment. These concerns faded as the counselors began to see improved engagement and results.

Counselors use the TIP's information on methamphetamine's neurobiological effects to ease clients' common fears that they may have damaged their brains or contracted a mental illness while abusing methamphetamine. Many clients are relieved to learn that the emotions and sensations that they have been feeling—such as euphoria, paranoia, auditory hallucinations, and violent behaviors while using followed by drastic drops in mood and energy levels and severe depression after stopping—are direct biological consequences of the drug rather than symptoms of an underlying psychological condition.

Based on information in the TIP about the brain's ability to repair itself over time, we tell our clients that current research gives grounds for hope that their symptoms will abate with abstinence, sleep, and good diet. We say this even though the research cited in the TIP suggests that chronic methamphetamine abuse has some long-term effects, such as decreased dopamine levels that can last as long as 4 years and psychotic symptoms that can sometimes persist through years of abstinence. We feel it is important, nevertheless, for clients to focus on the positive effects of abstinence rather than potential long-term problems they may or may not have to face.

Finally, we no longer encourage methamphetamine clients to consider using an antidepressant. The TIP's authors stress that empirical data have not shown that

these medications increase either retention or abstinence. The key to managing psychological symptoms is time away from the drug.

ISSUES IN IMPLEMENTATION AND EVALUATION

Implementation of TIP 33 at Prairie Ridge was considerably facilitated by the 44 worksheets included in the protocol (see “TIP Worksheets”). Nevertheless, the process was not simple, and we have not been able to evaluate results objectively.

Implementation

As mentioned, some staff entered the transition to the protocol's tolerant, client-centered approach with reluctance, although all ultimately recognized its validity. A more fundamental challenge for us was structural.

Prairie Ridge's programs follow the recommendations of the American Society of Addiction Medicine (ASAM), which promote multiple levels of care, including residential programs, halfway houses, day programs, partial day programs, evening outpatient care, and continuing care. To offer counseling to groups at all these levels of care with the resources available to us, we must mix together clients who are addicted to a variety of drugs. We do not have enough counselors to form groups of only methamphetamine users, only cocaine users, and so on.

We therefore could not implement all the TIP 33 recommendations, as some are irrelevant for clients who abuse drugs other than stimulants. For the recommendations we did adopt, we needed either to assume they would be helpful for all clients, even though they were validated only for stimulant abusers, or to use them only in individual sessions with methamphetamine clients. Ultimately, we compromised. We present most of the information to methamphetamine-abusing clients during individual counseling sessions, but we also use some recommendations in group sessions, such as giving gift coupons to encourage attendance.

We have found the overall philosophy of the TIP to be applicable to all forms of drug abuse treatment. The protocol stresses that the initial period of engagement is critical to the overall success of treatment, and we found that many of the strategies for engaging clients could be applied to all of our clients. We have instituted the client-focused approach across the board, presenting multiple treatment options and allowing clients considerable say in which they receive. Some of the work-

sheets included in the TIP seem to work well with many types of clients.

Evaluation Hurdles

Several factors prevented Prairie Ridge from objectively evaluating the effectiveness of the protocols recommended in TIP 33. To measure the success of any new intervention, a program must implement it with fidelity. The fact that we did not make use of every recommendation in the protocol in the exact manner it was prescribed, as well as the fact that we were already using some elements before its publication, prevented us from effectively evaluating the protocol.

TIP 33 is not presented in the same manner as many other treatment manuals. The protocol is presented as

We found the overall TIP philosophy applicable to all forms of treatment



a kind of cookbook, where some of the recommendations have been scientifically validated while others have not, and programs or individuals can decide for themselves how best to use the information. The manual does not lay out what a counselor should present during the first treatment session, the second session, the third, and so on; many details of implementation are left up to the individual treatment programs and counselors. It therefore is very difficult to determine the extent to which the TIP has been implemented and, consequently, its effect on the client population.

To determine if a manual such as TIP 33 is effective, executive directors and supervisors at treatment centers need to agree on a specific method of delivery and implement a monitoring system that holds counselors account-



Natalie Behring/Chisholm/Getty Images

*Parental rights
terminations
have dropped*

able for following the agreed-upon rules. Because of our method of implementation, we do not have data on whether our outcomes have changed since implementing TIP 33. Although we cannot quantify improvements across all Prairie Ridge facilities, we have plenty of anecdotal evidence suggesting that the program has been effective. Moreover, one of Prairie Ridge's smaller treatment programs has been more closely monitoring certain outcomes, which so far have been quite positive.

Our facility in Algona, Iowa, received state Department of Human Services (DHS) funding for a program to reduce out-of-home placements of children and terminations of parental rights resulting from methamphetamine abuse. Phil Heath, director of the Algona treatment program, employed TIP 33 to achieve these goals. In the past 2 and a half years since implementation of the TIP, there have been only two parental rights terminations because of methamphetamine abuse by parents subsequent to treatment, which is a significant reduction compared with past years. UA-confirmed abstinence rates during 2004 and 2005 were between


70 and 80 percent. In addition, in 2004, 62 percent of children who had been placed out of the home were returned to their birth parents. Nearly 100 percent of clients reported to DHS that they were satisfied with the treatment services. The original DHS grant was intended for a period of only 6 months, but success rates were so impressive that it has now been extended three times over the course of 2 years. The program also has been nominated for an award at the annual Governor's Conference on Substance Abuse.

CONCLUSION

TIP 33 broadened and deepened our understanding of the neurobiological effects of methamphetamine and the way that they affect clients in treatment, and also gave us a roster of evidence-based and consensus-based procedures from which to choose. We adopted the TIP's overall client-centered philosophy and instituted new policies of giving clients a period of rest before beginning treatment, treating relapse as an event in recovery rather than a termination of it, addressing clients' sexual problems, and conducting more frequent UA screens. We extended some of the approaches suggested by the TIP to clients being treated for abuse of drugs other than stimulants.

Largely because of our client mix and resources, we were unable to collect data to measure the impact of the TIP on our clients' outcomes. Accordingly, we are left with the question: Should the fact that the TIP interventions have been proven effective in other settings add significance to our very strong clinical impression that they have helped our clients?

CORRESPONDENCE

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REFERENCES

- Center for Substance Abuse Treatment, 1999. Treatment for Stimulant Use Disorders. Treatment Improvement Protocol (TIP) Series, Number 33. (DHHS Publication No. SMA 99-3296). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Prochaska, J.O., and DiClemente, C.C., 1984. *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones-Irwin.



RESPONSE: TIPSTERS WEIGH IN: PUTTING GOOD SCIENCE TO WORK

Felipe Castro, M.S.W., Ph.D.; Richard A. Rawson, Ph.D.; and Ewa Stamper, Ph.D.

Richard A. Rawson chaired and Felipe Castro and Ewa Stamper served on the 15-member consensus panel that created SAMHSA's TIP 33: Treatment for Stimulant Use Disorders.

Richard A. Rawson: The paper struck me first of all as a valuable personal account of a treatment program achieving positive outcomes with methamphetamine abusers. There has been a pervasive, unsubstantiated rumor that meth abusers do not respond to treatment. Recent studies (e.g., Hser, Evans, and Huang, 2005; Rawson et al., 2004; Roll et al., 2006) have begun to dispel that myth and prove that community treatment can produce results. The Prairie Ridge experience provides a clear instance of that.

I am pleased that Mr. Hansen felt that the TIP enhanced the tools and strategies they were using, and that it got a positive response from the staff.

Ewa Stamper: In my opinion, the program used the TIP extremely appropriately. They understood the most important thing, which was the client-centered, nonrigid approach. They also adopted the TIP's way of looking at relapse as a normal phenomenon in early recovery rather than treatment failure, and the need for a rest period before starting treatment. They got the key concepts; the details aren't so important.

Felipe Castro: Prairie Ridge seems to have done a good job of taking good science and modifying it as necessary to make it work in their circumstances. Unfortunately, other programs sometimes change things they don't like, take things out that aren't convenient, and end up with a watered-down rendition of the treatment that is unlikely to be effective. I call that mis-adaptation, as opposed to adaptation.

Rawson: We didn't intend the document to be a treatment manual. Our idea was to introduce ideas and concepts and allow clinicians to employ those they found useful. In that light, Mr. Hansen's struggles to apply TIP 33 with mixed groups of patients, not all of whom abused meth, were very instructive to read about. While there is good agreement that the patient-centered approach applies to all drug treatments, there have not been a lot of comparative studies on whether a particular set of protocols that was designed to treat one set of patients can also be used successfully with another. Without those data, I think clinicians logically should determine for themselves which strategies to apply widely and which only narrowly.

Castro: It is inevitable that clinical judgment will come into play in these situations, but it is important that these decisions aren't made haphazardly. Ideally, we should be able to teach clinicians how to make adaptations based on their local situation without removing the treatment from the context of the original, evidence-based approach.

Stamper: I was especially impressed by the spirit of continuing education and openness to new ideas among the staff at Prairie Ridge. Unfortunately, I don't think that's typical of rural or smaller centers. At least here in Hawaii, treatment providers sometimes tend to distance themselves from the research community and to be entrenched in what they know and what works for them.

Neurobiological and gender issues

Rawson: I found it very encouraging that the author made use of the information on the neurobiological effects of the drug on

the brain. For many treatment programs, the idea that neurobiology is relevant to treatment and recovery is revolutionary. I also was gratified that Prairie Ridge utilized the information on the sexual effects of meth abuse. I think that is an understudied area, despite its obvious importance to drug abuse treatment.

Stamper: The author's remark that there is inevitable discomfort when counselors talk about sexual issues made me sad, though it's understandable. It will be best for everyone if this discomfort is eliminated. Frankly, the more counselors are prepared and knowledgeable and practiced in talking about these issues, the less discomfort there is for both parties.

Castro: Most drugs cause sexual problems, either fueling or suppressing sexual drive. These problems may be more pronounced with stimulants than with other drugs.

I've been conducting research in a community residential program where we see only men. Almost all our patients have sexual problems and also problems with their families, where their role as protector and provider has been damaged by their drug abuse. The program addresses sexual issues as an important part of these broader gender and relationship issues that must be faced in treatment. In many cases, addressing sex and gender issues is a necessary step in helping patients return to society and their families, where there is a need to reconnect after the relationship has been damaged.

Stamper: Sex means different things for different genders. For female users, sexual issues are very often intertwined with issues of trauma, sexual abuse, and violence. They may also involve exchanging sex for drugs

(the dealer “boyfriend”), as well as prostitution. These things do tie together and they need to be addressed more and more.

Evaluation: Always recommended, always possible

Castro: I was disappointed that the author believed they couldn't evaluate their innovations because they were unable to implement the TIP with absolute fidelity. I think we can always evaluate, albeit with varying degrees of precision. All programs should be committed to some level of monitoring so that corrections can be made during the treatment process. Even asking a very simple set of questions in an exit interview, such as, “How much did the client like the information?” or “How effective did the client find it on a scale from 1 to 5?” can give a broad, but useful, idea of the efficacy of treatment.

Rawson: Consumer and staff satisfaction surveys are useful and relatively straightforward to do. In our program, when we implement new strategies and treatments, we monitor whether or not they improve retention. That is useful because people who stay in treatment longer do better. Drug screens can be used in a similar manner. A program can look at the 50 patients they treated before the change was implemented and the first 50 patients after and compare the results of their urine screens.

Stamper: I especially like the retention measure. It is certainly doable, and it's also immediately practical, through its connection to reimbursement. However, we do need to acknowledge that even the simplest measures require at least some invest-

ment of time and money. Everybody in a treatment program is overworked and usually no special funds are available for someone to sit and crunch these numbers. So the reality of the situation is: the simpler, the better.

Next steps

Stamper: I have been advocating for a revision to TIP 33 for several years. We know much more today than we did when we were writing it. A revision could incorporate new knowledge on issues such as special populations and neurobiology, as well as new evidence from clinical trials. I would also like to see an acknowledgment in the TIP that the majority of patients in treatment centers abuse multiple drugs. We could advise clinicians such as Mr. Hansen on how to deal with this issue, which he rightly treated as a major concern.

Castro: NIDA's big developments in neuroimaging research should be included in a revision.

Rawson: I would second that idea. The brain imaging work has taught us a lot about how some areas of the brain that meth impacts recover with abstinence, how that influences people's behavior during recovery, and what kinds of treatment techniques can be useful. We also now have a significant amount of clinical treatment outcome literature on both cocaine and methamphetamine, so there is a wealth of new information we could use to expand treatment recommendations (Rawson, Gonzales, and Ling, 2006).

Stamper: In addition to updating the TIP, I would suggest that we try to improve

our methods of dissemination. The TIP has not had much of an impact in my community.

Rawson: We've received very little feedback about the TIP. I have heard from programs in Iowa, which has mandated its use as a guide for treating methamphetamine abuse. The reports have been mixed. Some people, like Mr. Hansen, appear to have programs where people are open to new ideas. Other places have told me, “We don't see anything new about this. It's what we've always done.” That's a response I've been hearing for 30 years from people who base their treatment approach on their personal values and beliefs and don't want to be confused with information. Luckily, there is increasing awareness of the term “evidence-based practices” and the need to do things differently.

Stamper: Researchers and technology transfer groups need to find ways to disseminate science-based practices that fit counselors' cognitive styles. Among the Hawaiians in my community, and I imagine some other ethnic groups, the oral tradition is very strong. They will welcome face-to-face presentations with in-depth learning opportunities, but probably won't pick up a thick book. Counselors with less formal education tend to think very concretely. For them, a less conceptual, more cookbook-like presentation might work better. You don't need to have a broad conceptual framework to assimilate information creatively. &

REFERENCES

- Hser, Y.-I.; Evans, E.; and Huang, Y.-C., 2005. Treatment outcomes among women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment* 28(1):77-85.
 Rawson, R.A., et al., 2004. A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction* 99(6):708-717.
 Rawson, R.A.; Gonzales, R.; and Ling, W., 2006. Methamphetamine abuse and dependence: An update. *New Directions in Psychiatry* 26(3):221-236.
 Roll, J.M., et al., 2006. Contingency management for the treatment of methamphetamine use disorders. *American Journal of Psychiatry* 163(11):1993-1999.

Quality and Performance Improvement: What's a Program to Do?

A confluence of forces is challenging traditional approaches to issues of quality in substance abuse care. The availability of effective, research-based interventions, the Federal emphasis on performance measurement and outcomes, and national initiatives to improve quality and data infrastructure are driving a transition from a static, compliance-oriented approach to a more dynamic performance improvement model. This new way of achieving and documenting quality will produce better outcomes for consumers and greater confidence in the value of substance abuse services, but first it will require new behaviors from all parties involved in the delivery of substance abuse prevention and treatment services. This article describes some of the shifts already under way and offers advice on how organizations can get ready for the coming changes.

Frank McCorry, Ph.D.
New York State Office of Alcoholism &
Substance Abuse Services
New York, New York

Consider the following situations:

While cleaning your 16-year-old daughter's room, you come across a stash of pills. You've been aware of several changes in her behavior and attitude over the past 6 months. Her grades are down, and she has become surly and secretive; but you've been telling yourself not to worry, as surely all teenagers go through these phases. Now, standing in her room, you have the sinking feeling that your child is in trouble. After a heated confrontation with your daughter, you decide to call your managed care plan, which gives you the names of several programs and therapists available under your coverage. But how do you choose among them? You feel you may be confronting one of the most significant moments in your child's young life, but how do you decide whom to call, with your daughter's future possibly hanging on the decision?

You're the assistant secretary for human services in the Governor's office. You've been a thoughtful advocate for the needs of people with behavioral health disorders. This year's budget is going to require cuts in the substance abuse service delivery system. You dislike the "percentage cut across the board" approach to system management. You've visited programs and have a feel for which programs appear to work better, but you realize that your subjective opinion based on a limited number of site visits will hardly carry the day if programs are cut selectively. How can you manage the downsizing process so that it has the least possible impact on the overall effectiveness of the system and the care delivered to people in need?

A lack of quality information isn't the only challenge facing parents or system managers. Often, the available information is contradictory or lacks sufficient rigor

**Prepared Statement by Senator Chuck Grassley of Iowa
Chairman, Senate Judiciary Committee
Field Hearing on “A New Era in the Fight Against Methamphetamine in Iowa”
Tuesday, October 13, 2015**

Welcome to everyone here this morning. Today’s Senate Judiciary Committee field hearing is focused on the evolving methamphetamine problem in Iowa. Some may think meth is yesterday’s problem, and indeed it seems like other illegal drugs often make the headlines. But during my annual 99-county meetings, I’ve heard a lot recently about the persistence and changing nature of the meth problem in Iowa.

I’m told that meth-related treatment admissions are at an all-time high here. And last year, nearly half of all drug-related prison admissions in our state resulted from the trafficking or abuse of meth, also an all-time high. So meth is obviously continuing to impact Iowa in terrible ways.

Today I’d like to learn more about the current trends relating to meth here, promote awareness of the problem, and see if there are any new ways the federal government can help.

Meth is sometimes referred to as “the world’s most dangerous drug.” It’s highly addictive, and can methodically destroy lives, families, and communities. The children of meth users can face neglect, or health risks from exposure to the hazardous chemicals that are used to create the drug. Indeed, one of the unique aspects of meth is that it can be made at home by those addicted, by using common ingredients found in hardware stores and pharmacies. When combined, these ingredients are highly toxic and combustible, posing a threat to an entire household.

The risk that meth poses to families and children has been a concern of mine for many years. In 2006, I authored legislation that created a program to help support regional partnerships here in Iowa that provide treatment services, counseling, and skills training for families impacted by meth. The goal was to break the cycle of addiction, and to help keep families together.

In addition, Congress began erecting barriers to meth production in 2005, when it passed the Combat Methamphetamine Epidemic Act, which I was proud to co-sponsor. The law placed limits on the amount of medicine containing common meth ingredients, or precursor chemicals – like pseudoephedrine – that a customer can purchase at a time. It required pharmacies to sell these medicines from behind the counter. And it instituted a system to track sales of these substances to prevent bulk purchases. Iowa also passed a similar state law.

A few years later, I was one of the authors of the Methamphetamine Production Prevention Act, which became law in 2008. That legislation made it easier for pharmacies to use electronic logbooks to monitor sales of meth ingredients and for law enforcement to identify bulk purchasers. And a few years later, the Combat Methamphetamine Enhancement Act of 2010, which I also co-sponsored, strengthened this regime even further.

These laws have proven highly effective in drastically reducing the presence of meth labs in our communities. Today, law enforcement’s seizure of meth labs is at almost a 20-year low in Iowa.

That success is a tribute to the hard work of so many here, including Governor Branstad and Director Lukan.

So then, how is meth still such a problem? Where is the drug product on our streets coming from?

Some have resorted to using what's known as "shake-and-bake" or "one-pot" labs to cook meth. This is essentially using single plastic bottles to mix the ingredients together. This method remains highly dangerous, but can only produce small amounts of the drug. So this doesn't account for what's happening.

No, most of the meth in our state now appears to be coming from Mexican drug trafficking organizations. These organizations have entered the marketplace in response to the increasing difficulty of producing meth domestically. And they have virtually flooded the market with their product. Between 2009 and 2014, U.S. Customs and Border Protection reported a 300% increase in meth seizures on the southwest border.

The meth these Mexican organizations are trafficking into our communities, often referred to as "ice," is created on an industrial scale, through a process that leads to a much higher purity than meth produced in labs here. And it is far cheaper as well. It's no wonder the problem hasn't gone away.

So we need to keep looking for solutions at the local, state and federal levels. In the Senate, I lead an annual effort to maintain crucial financial support for state and local law enforcement. And earlier this year, Senator Feinstein and I introduced the Transnational Drug Trafficking Act of 2015. If enacted, the bill would make it easier for the Department of Justice to prosecute Mexican cartels who harm our communities by trafficking in either meth or its precursor chemicals.

I'm pleased to say that after my Committee passed the bill, it passed the full Senate last week. We're going to do everything we can to persuade the House of Representatives to act and send it to the President's desk for his signature soon.

All of our witnesses today have valuable experience and knowledge about the meth problem in Iowa. In particular, I'd like to point out the great work that our first witness is doing to support families in crisis due to substance abuse here in Iowa. Denise Moore is a former meth addict herself. Her story should give hope to anyone struggling with this awful disease.

I thank all of the witnesses for being here, and look forward to hearing their testimony. I now recognize Congressman Young for his opening remarks.

Terry E. Branstad

Governor

Kim Reynolds

Lt. Governor



Department of Public Safety

Roxann M. Ryan

Commissioner

To: Chairman Grassley and the Senate Judiciary Committee
 From: Paul Feddersen: Assistant Director of the Iowa Division of Narcotics Enforcement
 Re: Answer to questions submitted by the Senate Judiciary Committee
 Date: November 2, 2015

Dear Chairman Grassley and Committee members,

I wanted to take this opportunity to thank you for holding the Senate Judiciary Committee hearing in Iowa and taking the time to hear how methamphetamine, both imported from outside and manufactured in the state, has impacted Iowa.

- You have submitted the question, asking what strategies are law enforcement using to combat the smaller "one-pot" laboratories?

When the "one-pot" labs emerged in Iowa, an education effort that included a bulletin to raise awareness of the ingredients used and indicators associated with the "one-pot" process were shared with the public. The bulletin encourages the public to report suspicious activity to law enforcement.

Law enforcement also utilizes the state established tracking system that monitors the purchase of pseudoephedrine to combat labs. This tracking system prevents methamphetamine manufacturers from going to various pharmacies and purchasing the pseudoephedrine over the 30 day allowance. This system can be monitored to determine if there are continued or large purchases by individuals, including identifying possible associates involved in purchasing. Law enforcement can do follow up investigations to determine if these individuals are producing methamphetamine.

Another strategy that has helped law enforcement in the last year is the expansion of the state precursor law to include four substances used in the "one-pot" manufacturing process. It is now a felony to possess those items with the intent to manufacture methamphetamine.

- You also submitted the question if there are additional tools our office needs to help restrict "one-pot" laboratories in Iowa?

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Integrity, Fairness, Respect, Honesty, Courage, Compassion, Service

The Byrne-Jag funded anti-drug task forces are one of the main tools in the battle against methamphetamine and I would ask for the continued support for this funding. Earlier this month at the hearing I spoke of the Drug Enforcement Administration's Authorized Central Storage or "Container" Program that we now have implemented in Iowa. This program has also been an important tool for law enforcement, which in turn saves resources that enables law enforcement to continue to investigate methamphetamine labs and methamphetamine traffickers. Continued funding for this program and support from our federal partners is vital in the battle against methamphetamine.

Please let me know if you have any follow up questions or need any further assistance.

Sincerely,



Paul Feddersen - Assistant Director

Iowa Division of Narcotics Enforcement



STATE OF IOWA

TERRY E. BRANSTAD
GOVERNOR
KIM REYNOLDS
LT. GOVERNOR

OFFICE OF DRUG CONTROL POLICY
STEVEN F. LUKAN, DIRECTOR

To: Chairman Grassley and the Senate Judiciary Committee
From: Steven F. Lukan-Director Iowa ODCP
Re: Answers to questions submitted regarding testimony
Date: 30 October 2015

Dear Chairman Grassley and the members of the Judiciary Committee. I want to once again thank you for your leadership regarding anti-drug issues, and for holding the hearing in Iowa earlier this month regarding the impact of methamphetamine.

You have submitted follow up questions regarding the number of firearms seized in Iowa that have been involved with meth trafficking and the number of children harmed by methamphetamine in Iowa.

One of the key tools we have in Iowa to battle methamphetamine are Byrne-Jag funded anti-drug task forces. Often when task forces are working to disrupt drug trafficking and manufacturing organizations, they encounter individuals and crime scenes where more than one drug is present. Therefore, it is difficult to provide accurate numbers regarding weapons seized from methamphetamine activity and the number of children harmed in the production and use of the drug.

However, I have listed below a look at the past 5 years of data we track regarding these topics. As you can see, Byrne-Jag funding has been critical to helping children escape the dangers of methamphetamine production, distribution and use, and has also been instrumental in decreasing the number of firearms used in illicit activity.

Byrne JAG Funded Task Force Firearms Seized

SFY 2010	517
SFY 2011	745
SFY 2012	973
SFY 2013	547
SFY 2014	598
SFY 2015	915

*Note: We track the number of firearms seized, but cannot connect them to a specific drug type. Generally when there is a spike in the number of guns seized it is attributable to a couple of large seizures.

Byrne JAG Funded Task Force Number of Youth Referred to DHS

SFY 2012	410
SFY 2013	450
SFY 2014	300
SFY 2015	321

**Note: We track the number of referrals to DHS, but like the firearms I can't distinguish which drug type was involved in the referrals.

I hope this information helps answer your follow up questions. Please let me know if we can be of further assistance.

Sincerely,

A handwritten signature in blue ink, appearing to read "Steven F. Lukan". The signature is fluid and cursive, with a horizontal line underneath the name.

Steven F. Lukan-Director Iowa ODCP



Hearing Title: "The New Era in the Fight Against Methamphetamine in Iowa"

Presiding: Chairman, U.S. Senator Charles Grassley

Full Judiciary Committee

Date: Tuesday, October 13, 2015

Time: 10:00 AM

Location: 600 East Locust Street

Des Moines, Iowa 50319

Cowles-Kruidenier Auditorium of the State Historical Building

Written Testimony

Submitted by:

Anne Gruenewald

President and CEO

Four Oaks

5400 Kirkwood Blvd.

Cedar Rapids, IA 52411

Senator Grassley is a champion of foster care nationally and has been a supporter of Four Oaks as the lead agency for Iowa's statewide foster care and adoption work, in combination with five non-profit child welfare agencies and the Department of Human Services.

Senator Grassley also visited Four Oaks recently to look specifically at our work in the Wellington Heights neighborhood, to revitalize homes and help families in a more comprehensive way. We call that approach TotalChild. During that visit, Senator Grassley offered to consider supporting finance reform to help us better use existing funding in a more efficient and flexible way to sustain affordable housing and supportive services.

We also want to make the Senator aware that Four Oaks was awarded a federal demonstration grant, locally called PUSH-CR (Partners United for Supportive Housing – Cedar Rapids). It is one of five in the country that is showing how supportive housing for children and their parents in Iowa's foster care system have multiple challenges such as addiction, including meth, and are benefiting from a supportive housing approach. It's another example of a comprehensive/integrated approach in foster care, substance abuse treatment, mental health care, and affordable housing to get better results, faster.



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In the PUSH-CR project, many of the 60+ clients, enrolled in the first three years, have been meth addicts. So this testimony is intended to suggest that an important strategy to help meth addicts recover when they relapse – a quicker recovery and sustained behavior – will help them maintain housing, safely keep their children at home and advance in education and work towards self-sufficiency.

- PUSH-CR currently has 18 or 30% of our currently enrolled families that struggle with Meth use. Many of our families have informal supports with grandparents and siblings stepping forward to try to support the addiction. Most of these parents have excellent parenting skills and have fairly high skill sets being able to work, attend classes and appointments while battling their addiction. Several PUSH-CR participants have been successful in their battle against Meth addiction. Once client described meth use as a three day high that you can't get focused and she chooses not to use it again.

Here are two stories showing how meth is an ongoing issue with the clients we help to recover and stabilize through supportive services and affordable housing:

- A PUSH couple had a fire in the home due to allowing a peer to cook meth. The children were removed. They both completed treatment and the children have been returned and DHS case closed. The father is in federal prison for a minimum of five years, and the mother and children continue to stay involved with PUSH supports and activities.
- PUSH has a single mom who struggled in the first couple of months with getting clean from meth and other substances. She did impatient treatment and her children have returned and she has custody. She is close to getting the DHS case closed and has graduated from family treatment court. It took a lot of support and engagement for her to follow through with treatment and get clean. Once she was clean and mental health addressed she has been successful. She has been clean for over a year.

So, the struggle continues. PUSH-CR represents a complex merger of two systems—child welfare and housing—to serve some of the community's highest need families. This program represents a first-of-its-kind collaboration between the child welfare and housing systems to ensure that these families with the highest need receive the services necessary for stability and safety. With our continued support many of these families will experience success.

To that end, there are two pieces of legislation that we would like Senator Grassley to support. Senator Ron Wyden's legislation, The Family Stability and Kinship Care Act of 2015, as well as legislation from Senators Michael Bennet (D-CO) and Mike Crapo (R-ID), All Kids Matter Act <http://keepingkidsinfamilies.org/> are bills focused on adopting new ideas for improving child welfare policy and investments.

We hope that Senator Grassley will again be a champion for children with a look at how comprehensive, cross-cutting approaches, flexibly funded, produce better and more pro-active results.

October 13, 2015

Re: "The new Era in the Fight Against Methamphetamine in Iowa"

Dear Senator Grassley,

As a grandparent who has seen the impact methamphetamine use can have upon a family, I would like to share some of my observations regarding the problem and the effect on innocent children in the family.

Children from families with meth use are unnecessarily victimized as a result of their parent's personal problem due to the manner in which CPS handles these cases. Allegations of substance abuse are considered founded child abuse even though the child may have never been harmed in any way. Does the child face a risk of harm? Yes, if an intervention and treatment for the parent is not initiated. But what typically happens is, the children are abruptly removed from the home, placed in non-relative foster care, where statistics show is more abusive than the home from which the child is removed!

Iowa Supreme Court has ruled that a parent's drug usage does not indicate the child is imminently likely to be abused, yet week after week, children are the victims of child abuse allegations. The child is further punished by being restricted to weekly visits with the parents, often placed in another school or day care away from friends and relatives. Subjected to therapy and other interrogations, all while under the risk of being adopted out as a result of their parent's treatable problem.

This method of "child welfare" causes more harm to the child than what may have resulted in the home. Of course, we all know this aggressive form of "child protection" is all part of the current requirement in order for the state to receive federal funding to support child protection industry which has evolved into government funded child trafficking. An industry you are fully aware of.

A second concern is the fact that the "War on Drugs" is so well federally funded, that now another industry has evolved. With so much funding to be lost if and when the "meth problem" is successfully addressed, how diligent do you think efforts to solve this problem really are? In Iowa, it is so profitable, that the methods for drug testing, validity of the results and bidding for labs and collections sites are under investigation for fraud.

How many committees, councils, boards, commissions, agencies are profiting from the "meth problem"? This does not include the criminal justice system, whose livelihood depends upon the faults of others.

What about the federal, state, county and municipal employees who are given charge over the problem? Are they leading by example, by being required to do pre-employment and random drug testing as is done in the private sector? Why are they not included in a Drug Free Workplace policy like the private sector?

We know of a survey of Iowa DHS social services workers whose results revealed 96% of participants are using drugs and alcohol for stress reduction. How many are using meth and then crucifying parents for the same? Its time to end the hypocrisy and make everyone accountable.

Respectfully,
Nancy Augustine