COMBATING METHAMPHETAMINES THROUGH PREVENTION AND EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON EDUCATION REFORM

OF THE

COMMITTEE ON EDUCATION
AND THE WORKFORCE
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COMBATING METHAMPHETAMINES THROUGH PREVENTION AND EDUCATION

Thursday, November 17, 2005
U.S. House of Representatives
Subcommittee on Education Reform
Committee on Education and the Workforce
Washington, DC

The Subcommittee met, pursuant to call, at 10:04 a.m., in room 2175, Rayburn House Office Building, Hon. Michael N. Castle [Chairman of the Subcommittee] presiding.

Members present: Representatives Castle, Osborne, Souder, Musgrave, Davis of Illinois, Grijalva, and Hinojosa.

Staff present: Richard Hoar, Professional Staff Member; Lucy House, Legislative Assistant; Kimberly Ketchel, Communications Staff Assistant; Krisann Pearce, Deputy Director of Education and Human Resources Policy; Whitney Rhoades, Professional Staff Member; Deborah L. Emerson Samantar, Committee Clerk/Intern Coordinator; Jo-Marie St. Martin, General Counsel; Toyin Alli, Staff Assistant/Education; Lloyd Horwich, Legislative Associate/Education; Ricardo Martinez, Legislative Associate/Education; Joe Novotny, Legislative Assistant/Education.

Chairman CASTLE. A quorum being present, the Subcommittee on Education Reform will come to order.

We are meeting today to hear testimony on combating methamphetamines through prevention and education.

Under Committee Rule 12(b), opening statements are limited to the chairman and the ranking minority member of the subcommittee, who is Mr. Grijalva today. Therefore, if other members have statements, they may be included in the hearing record.

With that, I ask unanimous consent that the hearing record remain open 14 days so that all member statements and other exchanges of material referenced during the hearing could be submitted in the official hearing record. Without objection, so ordered.

Thank you for joining us today to hear testimony on methamphetamine prevention and education. We welcome the testimony of our witnesses as we seek to understand the nature of the meth problem in this country as well as some of the ongoing prevention and education efforts employed by local areas, states and the Federal Government that have been effective in combating the production and use of this dangerous drug.

We thank you, the panelists—panelist, singular, right now—for joining us today and appreciate your thoughts.

Methamphetamine, also known as meth, is one of the most powerful and dangerous stimulants available. It is fairly easy to produce because it can be created from common household or agricultural chemicals and cold medicines like ephedrine and pseudoephedrine.

According to the National Institute on Drug Abuse, NIDA, meth is a powerfully addictive stimulant associated with serious health conditions, including memory loss, aggression, violence, psychotic behavior and potential heart and neurological damage.

Meth abuse was once considered a regional problem concentrated mainly in southern and central California. Although this drug was once dominant in the west, it is now spreading throughout other regions of the country and emerging in cities and rural settings thought previously to be unaffected by the drug.

According to the 2003 National Survey on Drug Use and Health, 12.3 million Americans aged 12 and older have tried methamphetamine at least once in their lifetimes.

Meth production and abuse affect more than just the adults directly involved with this drug. Many children are being neglected by their addicted parents. The children who are removed from meth homes are often sick, and many wind up in foster homes.

The number of foster care children has been rising rapidly in states that have been hit by the meth program. As these children are moved around in the social service system, their parents may be in jail, awaiting treatment or not seeking treatment.

Children who are the victims of the methamphetamine epidemic are presenting many unique challenges to schools, social service workers, foster parents, counselors and adoption workers.

The Federal Government has recognized the importance that drug prevention and education efforts play in our communities. Prevention is also the most cost-effective approach to the drug problem, sparing society the cost of treatment, rehabilitation, lost productivity and other sociopathologies.

The administration oversees a number of prevention programs including through the Office of National Drug Control Policy and the Drug Enforcement Administration. Additionally, the Department of Education administers the Safe and Drug-Free Schools and Communities program, which is the Federal Government's major initiative to prevent drug abuse and violence in and around schools.

I look forward to hearing from our witnesses about drug prevention strategies that have been successful locally and nationally and where additional education and prevention efforts should focus.

Before yielding to Mr. Grijalva, I want to announce that unfortunately, because of my schedule, I am not going to be able to stay for the remainder of the hearing, so the vice chair of this subcommittee, Mr. Osborne, will now take over.

And at this time, I yield to Mr. Grijalva for whatever opening statement he wishes to make.

[The opening statement of Mr. Castle follows:]

Statement of Hon. Michael N. Castle, a Representative in Congress from the State of Delaware

Good morning. Thank you for joining us today to hear testimony on methamphetamine prevention and education. We welcome the testimony of our witnesses as we seek to understand the nature of the meth problem in this country as well as some of the ongoing prevention and education efforts employed by local areas, states, and the federal government that have been effective in combating the production and use of this dangerous drug. We thank you, the panelists, for joining us today and appreciate your insights.

Methamphetamine, also known as "meth," is one of the most powerful and dangerous stimulants available. It is fairly easy to produce because it can be created from common household or agricultural chemicals and cold medicines like ephedrine and pseudoephedrine. According to the National Institute on Drug Abuse (NIDA), meth is "a powerfully addictive stimulant associated with serious health conditions, including memory loss, aggression, violence, psychotic behavior, and potential heart and neurological damage."

Meth abuse was once considered a regional problem, concentrated mainly in southern and central California. Although this drug was once dominant in the West, it is now spreading throughout other regions of the country and emerging in cities and rural settings thought previously to be unaffected by the drug. According to the 2003 National Survey on Drug Use and Health, 12.3 million Americans age 12 and older had tried methamphetamine at least once in their lifetimes.

Meth production and abuse affect more than just the adults directly involved with the drug. Many children are being neglected by their addicted parents. The children who are removed from meth homes are often sick and many wind up in foster homes. The number of foster care children has been rising rapidly in states that have been hit by the meth problem. As these children are moved around in the social service system, their parents may be in jail, awaiting treatment, or not seeking treatment. Children who are the victims of the methamphetamine epidemic are presenting many unique challenges to schools, social service workers, foster parents, counselors, and adoption workers.

The federal government has recognized the importance that drug prevention and education efforts play in our communities. Prevention is also the most cost-effective approach to the drug problem, sparing society the burden of treatment, rehabilitation, lost productivity, and other social pathologies. The Administration oversees a number of prevention programs, including through the Office of National Drug Control Policy and the Drug Enforcement Administration. Additionally, the Department of Education administers the Safe and Drug–Free Schools and Communities program, which is the federal government's major initiative to prevent drug abuse and violence in and around schools.

I look forward to hearing from our witnesses about drug prevention strategies that have been successful locally and nationally and where additional education and prevention efforts should focus. I will now yield to Congressman Grijalva for any opening statement he may have.

Mr. GRIJALVA. Thank you very much, Mr. Chairman, and thank you for holding this very important meeting.

Ranking Member Woolsey asked me to apologize on her behalf, but a critical last-minute schedule change will prevent her from attending this hearing.

Meth is a growing and dangerous national problem of epidemic proportions in some areas. No longer confined to the Southwest and the West Coast, its use is now also transcending social classes and gender. There is no common denominator in categorizing a meth user. It could be your neighbor, a family member, a teenager, a mom.

What is common about this drug, however, is that it takes lives and ruins communities. Meth abuse affects the very fabric of communities nationwide. Just as meth abuse dangerously impacts communities, it is also best combated by a unified community effort involving parents, schools, retailers, law enforcement, health profes-

sionals, social service providers, treatment providers, and many, many others.

We are here today to discuss how Congress can play an integral role in this community in combating meth abuse through prevention and education. In recent years, Congress and the states have taken a hard-nosed approach focusing on restricting precursor materials and levying increased penalties and mandatory minimums.

My own state has followed suit. The Arizona state legislature recently passed a law which limits the sale of precursor-like products. But my hometown, Tucson, ravaged by meth use in recent years, has taken it one step further. Tucson passed an ordinance in October which keeps these materials available through over-the-counter drugs locked up behind pharmacy counters.

There is no question that combating meth abuse is one of the highest priorities to states and to our country. Arizona faces one of the highest overall crime rates in the nation and ranks first in the nation in property crime and motor vehicle crime.

It is estimated that an astounding over 80 percent of property theft crimes in Arizona are meth-related. And I think Arizona reflects our national problem. This July, the National Association of Counties surveyed 500 law enforcement agencies in 45 states, and nearly 60 percent responded that meth was their biggest drug problem.

There is a silver lining, though. Research confirms that as the perception of risk associated with a particular drug increases, use of that drug decreases.

One of my constituents, who is a recovering addict, stated if he had known the consequences for his health and the things he would do under the influence of meth, he would have never tried it. This is the message I think we need to bring home.

While it is obvious to adults that meth is a terrible thing, we cannot assume that that is equally obvious to all children and young people.

I am disillusioned, however, by our government funding efforts to this end. President Bush himself has stated that prevention is a key component of our drug control strategy and agenda. Why, then, have appropriators and agencies cut back on funding for prevention efforts?

In September I received a letter from the Pima Prevention Partnership, an antidrug community coalition in my district, one of the very entities which is so successful in bringing together all members of a community to combat methamphetamine use. They informed me that their drug-free communities grant had been terminated on questionable grounds and an appeal process denied.

But that was not an isolated incident. Sixty-three other coalitions were de-funded by the Office of National Drug Control Policy and 88 put on a 30-day probation. Both House and Senate appropriations bills cut funding for Safe and Drug-Free Schools and community state grants programs after President Bush proposed eliminating the state grants altogether.

The budget and appropriations bills we passed are not simply an accounting measure. They are a reflection of our values and also a reflection of the urgency of the needs that we confront. I do not

think the education appropriations bill that this House will consider reflects on us very well in that regard.

In closing, I would just like to add that one critical way for Congress to show that meth prevention and education is a priority is for us to devote more resources to it. My colleagues and I on this committee are committed to seeing that come to pass.

Today we have a very distinguished and experienced panel of witnesses. Our first panel is Representatives Souder and Hooley, who are Members of the Congressional Methamphetamine Caucus, who have introduced important methamphetamine bills here in Congress. Our second panel will provide insight from community, agency, research and judicial points of view.

Mr. Chairman, thank you for holding this hearing. I look forward to hearing from our witnesses about their work to promote meth prevention and education programs. Thank you, sir.

Mr. OSBORNE. [Presiding.] Thank you, Mr. Grijalva.

As a point of personal privilege, I would ask maybe that we take a quick look at charts here. I am not going to take more than about a minute. And then we will start with our first panel.

The chairman of the subcommittee mentioned that there had been a movement in methamphetamine abuse across the country. You see in 1990 there were two states, California and Texas, the red states, that had 20 or more meth labs, and the rest of the country was relatively untouched.

Look at the next picture there, and we see that by 2004 all but a handful of states in the northeast had been pretty much inundated by methamphetamine. So that movement is very pronounced.

I guess the good news: It is driving heroin and cocaine out. The bad news: It is more addictive, it is cheaper and it affects more people. And it is currently being distributed now by a lot of gangs that were originally distributing cocaine.

The last slide there simply shows what this does. Top left is a young woman, I am assuming somewhere in her early 30's or late 20's, and was arrested every year for 10 years. And you can see the disintegration. And the bottom left picture is the final picture after 10 years. It was taken in a morgue.

And obviously, she had aged many, many years, maybe 40 years, 50 years, in a 10-year period. And of course, a lot of people do not last that long on this drug. So some very graphic instances—recently went into a foster care situation where a young girl was 9 years old.

In her first 5 years, she had been in five different foster care situations. At age 5, her father told her no longer wanted anything to do with her. He was on meth. And so at age 5—we see kids at age 2 and 3 and 4 and, of course, babies affected by this drug. It is hugely expensive.

So having said that, I would like to start with our first panelist. Mr. Souder is detained with another vote, and we are privileged to have Congresswoman Darlene Hooley here, who has served in the 5th District of Oregon since 1997, serves on the Financial Services Committee, the Veterans Affairs Committee and the Science Committee.

Representative Hooley has been focused on eradicating methamphetamine in her district in Oregon for a number of years and

has truly been a leader in Congress in this effort, and we really appreciate this. She has recently introduced legislation to mount a campaign against meth on the regional, national and international levels.

And so I think you understand the lights and, you know, the procedures, so, Darlene, we are pleased to have you here today and we look forward to your testimony.

STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. It is my pleasure to be here. Thank you, Chairman Osborne and other members of the committee, and thank you for all the work that you have done on this issue. It is a scourge, and it needs all of our help.

In my three decades of public service, I do not think I have seen a problem as pervasive or damaging as the meth epidemic that is sweeping our country. Meth is one of the fastest-growing drug problems in the nation.

Meth is cheap, easy to make, and give addicts an intense, long-lasting high, destroys their brain, causes them to abuse and neglect their children, and leads to paranoid acts of violence.

Both Congress and state governments have been taking strong steps to address the supply of methamphetamine through precursor chemical controls and cracking down on international meth trade.

While we have focused on enforcement and precursor controls, too often we neglect the prevention and treatment piece. We know that both prevention and treatment can be very effective, especially from a cost standpoint. If we can use prevention programs to keep people from using meth and other drugs in the first place, we will save the taxpayer money.

But even more importantly, we can prevent the wreckage that comes when meth destroys an addict, harms a community and people around him or her. In fact, in my state, 80 to 90 percent of all property crimes are committed by meth addicts.

I am here today to talk about one innovative drug prevention program that has proven highly successful in Oregon. It is called the Methamphetamine Awareness Project, or MAP. MAP uses the creative energy and abilities of young people to create prevention messages through film.

Participating youth learn from and work with prevention and treatment specialists, law enforcement officials, their peers and professional film-makers to create public service announcements or documentaries intended to reduce teen meth use and raise community awareness about the dangers of meth.

The first MAP was during the 2002-2003 school year at Oregon's Sheridan High School. The Sheridan students produced a powerful 16-minute documentary that is now shown in many schools around Oregon.

The program was so successful in the first year that during the next school year, Oregon Partnership moved to Newberg High School, where the students produced two amazing television commercials that have been broadcast on television stations in Portland and have also garnered national attention from the Drug Enforcement Administration.

The first commercial that I am going to show is one of the ads.

(BEGIN VIDEO CLIP)

ANNOUNCER: Do you want to lose weight fast and have all your hair and teeth fall out? If so, methamphetamines could be right for you.

FEMALE: Shooting meth has really improved my self-esteem.

MALE: My teeth draw tons of attention.

MALE: I get so much done in such little time.

FEMALE: Look at all my scabs.

MALE: And I have met all kinds of interesting people.

ANNOUNCER: You will be amazed at what meth can do for you.

Meth is not for everyone. Symptoms may include paranoia, hallucinations, loss of senses, skin irritations, loss of brain cells, memory loss.

(END VIDEO CLIP)

Ms. HOOLEY. That was produced by the students at Newberg High School, and it is currently running on several television stations in Oregon, including Fox 12 in Portland.

The Methamphetamine Awareness Project continues spreading around the state. Last year we helped secure a grant for Lincoln County to bring MAP to their schools. For a total of $80,000, four schools were able to participate in the program, the end result being 12 public service announcements and two short documentaries.

Five of these broadcast-quality PSAs are now being shown on television stations throughout Oregon as well as having recently been sent to other states and Canada. This year the Office of Lincoln County Legal Counsel has secured another Federal grant to extend MAP to three more Lincoln County schools.

Here are two of the videos produced by Lincoln County schools showing two different tactics that the students chose.

The first, produced by students at Newport High School, features an interview with a former meth addict talking about the personal devastation brought about by the use of meth.

And the final ad, produced by students participating at MAP at Toledo High School in Lincoln County, was featured in a recent meth story airing on "ABC World News Tonight."

Do you want to show those two?

(BEGIN VIDEO CLIP)

FORMER METH ADDICT: When it comes to methamphetamines, once you start it, you think you are in charge. I guarantee you, you think you are in charge the whole time. And then all of a sudden, 1 day, you are lost, because before you know it, you are so addicted you cannot stop it.

I hurt people that mean a lot to me. I have nightmares about it. All over a bag of chemicals. I will regret the day I touched the stuff.

(END VIDEO CLIP)

Ms. HOOLEY. Do you have the next one? There is one last one.

(VIDEO CLIP)

Ms. HOOLEY. The students that participated not only learned firsthand about the devastation of methamphetamine through research and creation of these advertisements, but they are also providing a service to the community by educating them as well.

When they finished making these ads, they invited the whole community to come and see them. And these schools were all rural schools. And they had 400 and 500 people show up at night to watch these ads that the students made. So not only was it educating the students, but it was educating the community.

They had an after-school program. They learned some social skills. They learned film-making skills. They were given an outlet to their creativity. And again, it kept them busy after school.

But most importantly, the students were educating other students. They know best how to reach their classmates and what messages are going to be most effective in keeping them off drugs.

The Methamphetamine Awareness Project is truly an innovative project that ought to be examined closely by Federal drug policy experts and, I think, expanded on a national level. It is not very expensive. Again, it is a great way for students to educate other students that they know best.

And in fact, what I would love to see is this program go nationwide, and that these are the kinds of ads we use when we show the drug ads on television nationwide instead of those that are produced by professional companies. I think students know best how to keep other students off the drug.

I am happy to answer any questions. Thank you.

[The prepared statement of Ms. Hooley follows:]

Statement of Hon. Darlene Hooley, a Representative in Congress from the State of Oregon

Thank you Mr. Chairman and Ranking Member Woolsey.

In my three decades of public service, I do not think I have seen a problem as pervasive or as damaging as the meth epidemic that is sweeping our country. Meth is one of the fastest growing drug problems in the nation. Meth is cheap, easy to make, and gives addicts an intense, long-lasting high, but it destroys their brains, causes them to abuse and neglect their children, and leads to paranoid acts of violence.

People fighting against drug abuse frequently talk about the concept of the three-legged stool of prevention, treatment, and enforcement. Just like a stool, our efforts to fight drug abuse will collapse if we try to stand on just one or two legs. All three legs of our anti-drug strategy must be strong if we are going to be successful.

Another way to think about drug policy is to talk like an economist about supply and demand. We fight against drug supply through law enforcement efforts against drug dealers and by choking off the supply of precursor chemicals. We work to reduce demand through our prevention and treatment programs. And you have to reduce both supply and demand in order to make a dent in our meth epidemic.

Both Congress and state governments throughout the country have been taking strong steps to address the supply of methamphetamine through precursor chemical controls and cracking down on the international meth trade. While we have effectively focused on enforcement and precursor controls, too often we neglect prevention and treatment. Our lack of investment in these areas leaves us standing on a stool with two weak legs that is teetering and verging on collapse.

We know that both prevention and treatment can be very effective" especially from a cost standpoint. If we can use prevention programs to keep people from using meth and other drugs in the first place, we will save the taxpayers money. Even more importantly, we can help prevent the wreckage that comes when meth destroys an addict and harms the community and people around him.

I am here today to talk about one innovative drug prevention program that has proven highly successful in Oregon. The Methamphetamine Awareness Project, or MAP, originally developed by the Oregon Partnership, our statewide prevention coalition, combines substance abuse prevention theory with the creative energy and abilities of young people to create prevention messages through film. Participating youth learn from and work with prevention and treatment specialists, law enforcement officials, their peers, and professional filmmakers to create a prevention inter-

vention tool intended to reduce the potential of teen meth use and raise community awareness about the dangers of meth.

The first MAP was during the 2002–2003 school year at Oregon's Sheridan High School. The Sheridan students produced a powerful 16-minute documentary that is now shown in schools all around Oregon. The program was so successful in its first year that during the 2003–2004 school year, Oregon Partnership moved to Newberg High School where the students produced two amazing television commercials that have been broadcast on television stations in Portland and have also garnered National attention from the Drug Enforcement Administration.

One commercial depicts a doctor standing in his office, wearing a lab coat and holding out a bottle with a devil carrying a pitch-fork on the label. Techno music plays in the background as the doctor begins his pitch. "Do you want to lose weight fast, and have all your teeth and hair fall out?" he asks. "If so, meth could be right for you." Another ad, that has been featured on the DEA's youth education web site, features a young man pouring a variety of chemicals into a blender, including kitty litter, brake fluid, gasoline and cold medicine: all methamphetamine precursors.

The Methamphetamine Awareness Project continues spreading through the state. In the 2004–2005 school year, I helped secure a grant for Lincoln County to bring MAP to their schools. For a total of $80,000, four schools were able to participate in the program, the end result being 12 PSA's and two short documentaries. Five of these broadcast quality PSA's are now being shown on television stations throughout Oregon, as well as having recently been sent to other states and Canada. One was even featured in a recent meth story airing on ABC World News Tonight. This year, the Office of Lincoln County Legal Counsel has secured another federal grant to extend MAP to three more Lincoln County schools.

These ads include one depicting a father who is too busy cooking meth for himself to worry about food for his family as the police bust his home meth lab. One of the schools participating in MAP, chose to create interview-style public service announcements where they went out to the community and spoke with recovering meth addicts about their experiences. Another provides kids with a list of "Better things to do than meth" including watching halftime shows, going to a movie and going to dances. The ad ends with the tagline "Meth is Death."

The project works on several different levels. The students participating in MAP not only learn first hand about the devastating effects of methamphetamine through the research and creation of these advertisements, but they are also providing a service to the community at large by educating them as well. Research has shown that interventions that provide opportunities, skills, and recognition are likely to promote positive social bonding and the adoption of healthy beliefs and clear standards of behavior. MAP participants are drawn into the program with the opportunity to acquire and utilize film skills in a context where they are reinforced by adults and peers. Not only are they learning about the dangers of methamphetamine and film skills, they are also learning to exercise their creativity and given an outlet that keeps them busy after school hours. But most importantly, it is kids educating other kids. They know best how to reach their classmates and what messages are going to be most effective in keeping them off drugs.

RMC Research Corporation, based out of Portland, Oregon, is conducting a three-year study to measure the effectiveness of MAP's prevention strategy. Although they are still in the progress of evaluating the results of the program, the initial study results indicate that MAP has been successful in decreasing the likelihood of youth substance use. MAP accomplishes this through four main tactics. It increases knowledge of the negative effects of meth and other illegal drugs among program participants. It increases and/or maintains anti-drug attitudes. It increases adult and social bonding and finally, it increases overall protection and resiliency.

Early study results score the program high in a variety of categories including participant satisfaction, knowledge gain and skill development. Participants in MAP learned facts and risks related not only to meth, but also ecstasy, other club drugs and illegal drugs in general that supported their desire not to use. Not only was the program effective in educating the students about the dangers of meth use, but program participants also reported decreased risk related to tobacco and marijuana use following participation in MAP.

Although quantitative benefits from MAP are still being determined through the associated research efforts, the communities involved in this unique initiative have reported that the project has been beneficial to their communities, both students and adults. Because of the attention that MAP has received in the media, it has increased knowledge about meth and reinforced anti-meth attitudes throughout the entire state and the videos that the students have created have been shown at anti-meth forums and events across all of Oregon. The Methamphetamine Awareness

Project is truly an innovative project that ought to be examined closely by federal drug policy experts and expanded on the national level.

Mr. OSBORNE. Well, thank you very much. Excellent. And certainly the PSAs are, I think, very effective. At least they affect me.

I guess I just have a couple quick questions.

One is, as you mentioned, this has hit a few counties, probably not even in the whole state of Oregon.

Ms. HOOLEY. No, no, a few schools.

Mr. OSBORNE. A few schools. And you mentioned that you would like to see this comprehensive, nationwide if possible. I certainly agree. Do you have any thoughts as to—you know, obviously, funding is a problem. And I think one of the things we are doing today is simply try to build awareness. Maybe people in Congress will pay attention.

But sometimes this whole thing seems to be flying a little bit under the radar screen, and I wonder what your perception is as to what the most effective way would be to get this translated to a national level, a national scope.

Ms. HOOLEY. Well, I should have the numbers with me, and I will get those to the committee. We spend a fair amount of money, and I know a lot of it—the time and the energy is donated—not energy, but time is donated by professional ad companies.

But what we spend on advertising every year on drug ads—I think we could use some of that money or most of that money and put it into our schools and let our students make those ads.

We have incredibly talented students. And if they have a little bit of help from some film-makers or some other people that have some expertise, I think this could spread nationwide. And then show these instead of the professional ads we have done.

And again, I think these ads have more of an impact than some of the ads that are done professionally, again, because they are done by students and they know what impacts other students better than anybody else.

So I think there are some ways—and we have some proposals on where to get the money, and I would be happy to bring it to you, and I do not have it with me today.

Mr. OSBORNE. I think those comments are certainly well taken, very appropriate. Have you given any thought to age appropriateness? In other words, this is primarily aimed at the high school student.

Ms. HOOLEY. We think it is appropriate to use in junior high. I mean, again, it has not been used in that many schools in Oregon. I think it is gone in about seven schools. And one of the schools was a junior high. And what they came up with was absolutely terrific.

And in the process of doing these PSAs, they have also done documentaries. And some of them are 15 minutes. One is 16 minutes. One is 10 minutes. But they have done some documentaries as well, and they—I mean, I think they have done a terrific job.

But I think it is very age appropriate for junior high, which is, I mean, the age that kids are experimenting. They want to be an adult 1 minute. They want to be a kid the next minute. Lots of

young women are using this as a way of losing weight. And I think junior high is as appropriate as high school.

Mr. OSBORNE. The reason I mention that is that there are some who are even suggesting as low as 3rd or 4th grade, at least with some materials, because that is when people start shaping their thoughts about substance abuse.

And of course, underage drinking on average, I think, starts at about 12.7 years of age.

Ms. HOOLEY. Right.

Mr. OSBORNE. And of course, lots of people when they are high on something else will take meth when somebody says, well, here, try this, you know, this will make you really feel good. They do not even know what it is.

Ms. HOOLEY. Well, I think a documentary that students make can also be used as one of the many tools they would use in grade school, in 4th and 5th and 6th grades as well. So I mean, I think that could be part of a curriculum.

Again, as you said, younger and younger students are using drugs and alcohol. And I mean, I think the numbers are pretty—as far as how young kids are starting to use some kind of substance abuse.

Mr. OSBORNE. All right. Well, I do not want to take more time at this point. I just want to thank you for your testimony and thank you for coming.

And at this point—oh, I see our other witness, Mr. Souder, is here. So we probably should at this point welcome him and allow him to testify, and then we will turn the questioning over to other members of the panel.

Mark Souder has been very active in methamphetamine legislation. He has been a representative of the 3rd District of Indiana since 1994 and chairman of the Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources.

So his subcommittee has done a great deal of work and has jurisdiction over domestic and international antidrug efforts for the Federal Government—is authorizing the Subcommittee for the Office of National Drug Control Policy.

He also serves on this committee as well as the House Committee on Homeland Security. And I know Mark just had a series of votes.

And we are pleased to have you here, Mark, and so why don't you go ahead with your testimony at this time?

STATEMENT OF HON. MARK SOUDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. SOUDER. Thanks. And knowing my full testimony will be in the record, let me just summarize a couple of points.

I apologize; we were voting in Homeland Security.

And I want to thank Congresswoman Hooley and, as I referred to you yesterday, Coach Congressman Governor Osborne, for his leadership on this issue. It looks like either today or tomorrow we are going to have the first major meth legislation in the history of Congress on the House floor. Congresswoman Hooley has some elements of this in the international area.

The pictures that you have steadily brought to the House floor have helped develop attention among members of the devastation of this disease. And we both have a war on drugs and a health crisis on drugs. They are both things, and meth is the latest iteration of this.

There is a couple of different points I think are most relevant to the Education and Workforce Committee. I have held 11 hearings around the country on meth and seen many variations of rural and urban. Clearly, this committee has jurisdiction over Safe and Drug-Free Schools which will be coming up as we reauthorize the No Child Left Behind, the elementary education act, that will be coming up. This committee also has important jurisdiction over the workforce.

And let me immediately address more precisely what is in front of this committee and then more broadly some prevention efforts. I believe that the legislation we are about to pass will start to get control some of the international market.

That combined with what we are doing in Homeland Security and Judiciary will address some of the border questions. We have some meth kingpin and over-the-counter legislation. That buys us time.

But ultimately, when we do law enforcement and international enforcement, if it is not coupled with prevention and treatment—can only stabilize or slightly slow the growth. It does not accomplish the purpose.

We also have to get the prevention message out and then treat the wounded so they do not keep coming back. In some cases in labs—we had one in Indiana just a couple weeks ago—the prosecutor told me he was up for his third mom and pop lab, and he still had not been in jail for the first one because it takes so long to get to prosecution. Others, the second they are out of their treatment program, they are back in. So we need much more research and treatment.

But as we look at prevention, the Safe and Drug-Free Schools program presents an interesting challenge to us, because on the one hand, we have tried to do so much with this program that it has not been targeted enough. And I think we need to look at that as we do reauthorization.

A second thing is as much of the meth problem is located in rural areas, and in our allocation formula by school, often a rural school—sometimes they get $300, sometimes $700. It is not really enough to put together a coordinated campaign.

And we need to look at how to do some pooling in the rural areas, because the way Safe and Drug-Free Schools is structured, it would be very hard to get dollars into many of the areas where the meth has hardest hit.

I think a third aspect of Safe and Drug-Free Schools, which is a different type of challenge, is that when we are doing Safe and Drug-Free Schools, meth is not predominantly a youth drug.

Now, we want to do the education and the prevention so they do not get into it later, but part of the reason I mentioned the importance of workforce here is I think the frontier that we need to tackle next year, in addition to some of the EPA questions and some things that—clearly, ONDCP needs a meth clearinghouse.

We need to see what has worked in Montana, what has worked down in Kentucky—two success programs we have. And right now, when you talk to local groups, they do not even know where to go to get this. Association of Counties does some of it. Individual congressmen do some of it. Sometimes it is a community coalitions group that does it.

We clearly need a clearinghouse. And I think ONDCP can do that without legislation. But if need be, we do legislation.

But where we need to really look at this is this drug seems to be concentrated most heavily in the workplace. And in this committee we need to look at this. Small Business Committee—we need to look at this—because often it seems to be a combination of—in some cities, like in Minneapolis, we heard that the bulk of the people who were in meth treatment were women. An extraordinarily high percentage were using it for weight loss.

Other areas, it is just a standard, "I am out on drugs and this one got me higher." And then one of the things that we have seen in my home state is it is used like an amphetamine, and many truck drivers use it. They can stay awake longer, at least initially, till they get devastated and lose their job. And people use it like that.

Well, a standard national ad campaign or a standard Safe and Drug-Free Schools program is not really going to work in the workplace. We need to get where they are. So we have been asking Partnership for Drug-Free America for—are we going to have posters we can put at the workplace?

Are we going to have things that we can put in with the check when they get their payments? Are there things that we can target at the workplace? Do we look at drug testing in the workplace? And how can we—a number of years ago we did this with the small business. So we need to be creative.

One last point: The Partnership for Drug-Free America has offered their new anti-meth ads to any Member of Congress who will do this. The T.V. ads are done. They are very near completion on the radio ads, and they are working on billboard and newspaper ads that should be available by the 1st of the year.

I encourage every Member of Congress, rather than just talk about this, if you have meth in your district, to lead the prevention effort. Get these materials. Go to your T.V., go to your other media outlets in the district, and work with the high schools, too. They have little T.V. stations, radio stations. They can put posters up.

And I think if we work together, as we have been here in Congress, we can really turn the tide on this drug, because it is the easiest one to sell that we have ever had in modern times—to say this is what it does to your body, this is what it does to you.

Thank you for letting me testify.

[The prepared statement of Mr. Souder follows:]

Statement of Hon. Mark Souder, a Representative in Congress from the State of Indiana

Chairman Castle, Ranking Member Woolsey, and my colleagues on the Subcommittee, thank you very much for inviting me to testify on this very important subject. I'd like to commend the Subcommittee for holding this hearing, which addresses one of the critical components of our effort to stop the methamphetamine epidemic: meth use prevention and education.

As chairman of the Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources, I've held eleven hearings on the meth epidemic, including seven field hearings. In places as diverse as Indiana, Arkansas, Hawaii, Minnesota, Ohio, and Oregon, I have heard gripping testimony about how this drug has devastated lives and families. But I have also learned about the many positive ways that communities have fought back, targeting the meth cooks and dealers, trying to get addicts into treatment, and working to prevent abuse, by educating young people about the risks of meth.

"Prevention—stopping use before it starts," in the words of President Bush's National Drug Strategy Report—is a vital component of any effective drug control strategy, and that is particularly the case for meth. In many respects, it is the most important component, since it is the demand for drugs that attracts the supply. Moreover, as with anything else, an ounce of effective prevention really is worth a pound of cure. Once a person is addicted, treatment is very difficult—especially for meth. While many people correctly state that we will never simply arrest our way out of the meth problem, neither will we simply treat our way out of it, either. If we don't cut back on the number of addicts, we will never be able to provide enough effective treatment for all of them.

Prevention must therefore be central to our anti-meth strategy. Even as the House and Senate consider legislation to reduce the diversion of meth precursor chemicals like pseudoephedrine, we must also consider how best to prevent the "diversion" of young lives to the destructive path of meth abuse.

The federal government's major prevention programs include the Safe and Drug–Free Schools (SDFS) program at the Department of Education, which includes formula grants to the states, and "national programs"; the National Youth Anti–Drug Media Campaign (the "Media Campaign") at the Office of National Drug Control Policy (ONDCP), which helps fund a national advertising campaign to educate young people and parents about the dangers of drug abuse; the Drug–Free Communities (DFC) program at ONDCP, which provides small grants to local "coalitions" of organizations and individuals who come together for drug use prevention efforts in their communities; and prevention programs funded through grants provided by the Center for Substance Abuse Prevention (CSAP), part of the Substance and Mental Health Services Administration (SAMHSA) at the Department of Health and Human Services (HHS). The federal government also funds significant research and development of drug prevention methods, through CSAP, and the Counterdrug Technology Assessment Center (CTAC) at ONDCP, and the National Institute on Drug Abuse (NIDA).

At a hearing last April, I expressed my concerns about the Administration's budget proposal for drug use prevention programs in general. By proposing to eliminate the SDFS state grants, flat-funding the Media Campaign and DFC programs, and reducing SAMHSA's prevention funds, the Administration would have reduced prevention funding to only 13% of the fiscal year "06 drug control budget. Although the Administration has valid concerns about how effective our prevention programs have been in reducing drug use, I believe the appropriate response is to reform the existing programs by making them more accountable, or to propose new and better programs. The Administration's deep cuts, unaccompanied by any new proposals, would have suggested a significant abandonment of prevention.

I think that Congress and the Administration need to come up with a comprehensive strategy for drug use prevention, starting with meth use prevention. I am pleased that ONDCP has finally begun producing ads through the Media Campaign targeting meth use; we need more of them, and a commitment to ensure they are broadcast in the most affected areas of the country. Targeted ads against "ecstasy" had a real impact in recent years in reducing youth abuse of that drug; targeted ads against meth hold similar promise.

With respect to Safe and Drug–Free Schools, I firmly believe that program can play a vital role in meth prevention. We need, however, innovative thinking and new ideas about how to communicate anti-drug messages in the schools. Among other things, I think that at least some part of those funds should be available to help schools implement targeted, non-punitive drug testing programs. Such programs would help vulnerable kids stay off drugs, and kids already heading down the road of abuse to get into treatment. They are also an excellent tool for measuring the success of other drug use prevention programs, as they show whether the true "bottom line"—reducing drug use—has been achieved.

Thank you again, Chairman Castle and Ranking Member Woolsey, for your leadership and commitment to improving meth prevention programs. I hope to work with you, and all of my committee colleagues, to move forward a comprehensive meth prevention plan.

Mr. OSBORNE. Thank you, Mr. Souder.

And one thing that we have done in my district—my staff and I are in every middle school, every high school, with a PowerPoint showing some of the more graphic stuff, and we feel it has made a difference.

I have already had a series of questions, and so at this point I would like to turn to Mr. Grijalva. Oh, he is gone.

Mr. Davis?

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman, and let me begin by commending Mr. Souder and Representative Hooley for the leadership that they have demonstrated.

Mark has been relentless as chairman of the drug committee. It really should be called the antidrug committee, because I have seen him all over the country trying to help educate, bring awareness, and really trying to get a handle on what I consider to be one of the most serious problems facing America, period.

And of course, it has worldwide implications because you see it when you travel abroad. And it is one of the problems that we have not been able to seriously get a handle on.

And I am always perplexed when we talk about costs and finding the resources to do education and prevention, because we can obviously see it is not a matter of spending. It is a matter of investing, and that if we do not invest on the front end, then we are going to spend on the back end, but think of all the misery that has occurred in between that could have been prevented.

And I just do not understand why we seem to have so much difficulty understanding that, or why we have so little faith in education. Smoking is one of the best examples that one can think of. Twenty years ago, there would have been smoke all over this room. Ten years ago, we would have separated the smokers, and they would have been in the back on one side.

And now we have finally come around to realize the danger of smoking as a result of intense education campaigns. It did not happen by itself. I used to smoke cigarettes when I was a kid, and I smoked them because I did not know any better.

My mother used to tell us that if you know better, I believe that you would do better. And I think if our country knew better, if kids growing up knew better, if people in the workplace knew what drug use will do for and to them, they would do better.

And so my question is, Mark and Darlene, how do we convince what seems to be an unbelieving public that it really makes sense to invest? If there is no investment, there is no return. We understand that. We live in a capitalistic society. We always have.

And if we do not invest in programs like the MAP program, then we have got to invest in the hospitals. We have got to invest in the morgues. We have got to invest in trying to cure some of the poverty.

But how do we convince an unbelieving public that it makes sense to invest in prevention and treatment?

Ms. HOOLEY. First of all, we need you going around the country giving that message everywhere we go. That would help.

And as you know, most education programs—it takes a while to get—first of all, to convince people in this building that this is an important program that we have to invest in.

The other day I was talking to a couple of addicts, former addicts, and some judges, and they have a very successful court program. When the judge has the carrot or the hammer, whether the person goes to jail or they go to a treatment program, the cost to put them in jail is $25,000 a year. The cost to treat them for a year is $2,400.

Now, I have been trying to figure out why, if we save that jail time, we cannot take that—and by the way, in this program, because they do not have any money to run the program, the addict has to pay for it themselves. And how many addicts can pay for it themselves? And sometimes they have parents or family members that will help do this.

But why can't we take some of that saved money from that jail time to pay for the treatment program. But I mean, again, it is all of us coming together and saying this is important to invest in. This destroys families. In my state, we have had increase in number of foster homes needed because of children that are in meth homes.

It is costing all of us a ton of money. It is always much easier or we always save money if we invest. And I think it takes the will of all of us that we understand this issue is a problem, and it is going to take our will to find that money to invest in the prevention programs.

Mr. SOUDER. If I can make a couple comments on this, I think that there are several things. Some are real and some are perceived. One is that the impact of education is delayed. And as legislators, we tend to want to address the problem in front of us, get immediate thing, and then move on—particularly those of us who run every 2 years—want to fix the problem, and we do not want to say it is still continuing.

And so when you have a prevention program, it is a delayed impact, whereas when you are dealing with a crime or somebody who is violent or making a drug lab, it is immediate.

I think a second thing is—and this is a criticism of some of the prevention movement—that the accountability historically has been less on prevention than it has been in other types of categories. And because it is more vague, and you already have this delayed effect, it becomes more difficult when there is a budget thing in front of you to take it.

And we need to make sure that our prevention programs are actually targeted with results that are measurable. To the degree that we do, we will be more successful and make sure we are hitting the target.

But I think all that said—also, one other thing that makes a problem here is when we look at Federal investment, the fact is that the costs of not investing in prevention are split. The state picks up some, the county picks up some, the schools pick up some, the individuals pick up some, the families pick up some.

And therefore when you are looking at your limited budget, unless we can get the state, local, federal, private working together for a combined effort, then no single group has the incentive to do the prevention.

But let me illustrate why I believe in certain things it becomes absolutely appalling if you do not get into prevention. And let's just

talk about what happened with crack and now I think is happening with meth.

In my home town, we got hit with crack and most of it was coming in from Detroit, not Chicago, because crack hit Chicago later. But because it was not there yet, they were not trying to prevent it. In meth what we see—and we have heard this myth that it does not hit in urban areas and it does not go into the black population.

Yet in Minneapolis, we have seen it now in Omaha, we have seen it in Portland—that when certain groups, distribution groups, see that they can cut out the Colombians and make more money on crystal meth, hey, they are right to crystal meth.

So in Chicago, we ought to be looking at aggressive prevention before it hits, not trying to clean up the mess afterwards. And so prevention is much harder once it has grabbed than when you can sell it in advance.

So I think if we get more sophisticated prevention methods, organize it better, and coordinate, we can overcome some of the past resistance.

Ms. HOOLEY. Can I just add one other thing? And you said it, because we are elected every 2 years. I think it is being persistent and consistent in sustaining that for a number of years. You cannot go on from the issue of the day to next week another issue and next year another issue.

You have to really stick with this issue.

Mr. OSBORNE. Thank you very much.

Ms. Musgrave?

Mrs. MUSGRAVE. Thank you, Mr. Chairman.

This meth situation just breaks my heart. I mean, in rural areas where you can have labs out, you know, where it is isolated, the toll on our children is absolutely horrific.

And I was just absolutely incredulous the other day. A member of our city council in the rural community—I live a little bit south of it—was arrested for cooking meth in his home. And you know, I am not saying he is guilty, but that is what he was arrested for. And to me, that spoke to the addiction that someone even after they have moved on still cannot kick.

And I was at an apartment complex recently and I saw this young woman with a toddler on her hip, and she was there, and she was talking to me, and her teeth were just rotten. She is this beautiful, young woman. It was meth mouth that I was looking at. And here she was a mom. And we have to do something.

And, Mr. Davis, your remarks about spending on the front end or the back end and the misery in between—I mean, the misery just breaks your heart. And in my district, I have a vast district, and we have 75 percent of the population living along the front range, and then we have 25 percent out in the rural area. And Mr. Osborne knows very well what those rural areas are like.

So we are seeing the devastation of meth. I have a son-in-law that is a police officer, and he is just overcome with what this is doing to rural America.

And then when you get a little closer to the front range, in another community that I represent, we have had a number of deaths, gang related deaths, and it is because of methamphetamine. And you know, I am all for peers educating peers, these

kids. But we have got to get a hold of this problem and do something.

And I did not even know, Mark, that we could do ads. I did not even know that. And you can bet that I will be participating in any way possible. And when these—I think we need ads that let these young people know that this just kills you from the inside out, and if you want to lose weight and look great, you know, you better think of the teeth, you know, that you are not going to have, because they are going to be just melting in your mouth.

So I applaud you on your efforts. I really do not have a question other than, you know, get me on board and let me do what I can do, because it is devastating. And I think in these small towns that the chairman and I would be familiar with, because we see people in the grocery store, and we talk to a mom whose daughter has died because of her meth problem, we have that level of intimacy where we see it.

It is not in a big town. It is not lost. You know, it is your friends and neighbors, the teachers you know, and the law enforcement people that are affected by this, and the effect is just horrific.

Thank you, Mr. Chairman.

Mr. SOUDER. May I comment briefly? The partnership is going to show two of the ads in the next panel. And they are effective in different ways, one showing the impact on family, one is more chemicals.

But sometimes we as politicians—I mean, I have never even smoked a cigarette. I am not a really good test case here. And so I am kind of naive as I approach this type of issue and communicating it, and so it has been hard for me to understand why somebody gets on meth.

And we really have to pound the pictures here like Congressman Osborne has done and the immediate impacts, because we—one of the people at Oregon, which was kind of appalling, and please, everybody, cover your ears if you are not ready for this, but one of our witnesses said it was 12 times more—the impact was 12 times greater than the best orgasm he has ever had, that people can drive three nights without sleeping, that they can up their performance at work, because the question is what gets them into this.

Given that we have these warnings, why do they go to meth? And we have to understand why they do, because we see doctors, we see lawyers, we see people who say this is not logical that this has happened. Now, what we need to communicate is that it does not sustain itself. That might work once or twice, but you get addicted to this stuff, you look like that lady, or you die, or you cannot perform at all.

When you actually talk to meth addicts, they may get some short-term performance and short-term excitement, but this, unlike any other drug, has a "boom", like that, on you, and if we cannot communicate that clearly, then we are lacking communication skills.

That is why I say this is a drug where we can show clearly—and the chemicals going into this—smoking has rat poison. This stuff has about every kind of poison dumped into your body. If we cannot communicate this, and if we cannot spend some dollars communicating this, it is not clear what we can communicate.

Mr. OSBORNE. Thank you very much for your comments.

And I would just add one comment here. One thing that is really difficult about CBO scoring is it never takes into account savings. And therein lies the rub here in Congress, because we talk about the importance of investment. We talk about the importance of prevention.

And so you may spend $3 million to save $1 billion, but it does not score. You know, it just scores $3 million spent. And that is the thing that is so hard to get across. And it really ties your hands.

I am sorry, Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Mr. Chairman, and I thank you for calling this hearing.

I thank our colleagues, friends and colleagues, for coming to better inform us on this very important, critical issue of drug prevention.

I was looking at the testimony and wanted to ask Representative Hooley—it seems that you testified about our lack of investment in the antidrug prevention and education.

Can you expand on that a little bit more for us and talk about how we need to improve that area?

Ms. HOOLEY. This is an issue actually I have been working on for 17 years. And when I first started, it was all about the expenses of how do you clean up a meth lab, so it was all about law enforcement and how you clean up—very expensive process, and trying to get money into our communities for law enforcement for cleanup efforts.

Again, because it is so hard to show savings with prevention, as Mr. Souder's pointed out, it is split so many ways. I mean, and you have to have a prevention program that comprises more than just one thing. I mean, it has to be—but all of us learn differently, and so we need to do a variety of prevention programs. And a big portion of that is education.

This Congress has to take a look at what has been done in communities, what has seemed to work—for example, we know that if we get the younger students that we are usually better off. But a lot of times, we do not trace that from grade school through high school through college and on.

We take a program that we think has worked—for example, Just Say No. Well, most of the literature I have read—maybe it has worked, and maybe it has not, but most of the literature I have read, you know, has seemed to say that it has not been terribly successful. But maybe you can change that or take a little different tack.

One of the reasons I brought these T.V. ads in—that may not work for everybody, but it is a way of students doing hands-on work, learning about it on their own, making ads that they think are effective for other students. And I think that is one of many programs that we can do.

But let's try all of them, and let's see which ones work. And you know, maybe we will find a couple of silver bullets. I doubt it, but maybe we will find a couple of ones that are just the thing. But let's put some real effort and some real time and some real money into prevention.

We are trying to deal with the supply problem in our bill. Let's try to deal with the demand problem as well.

Mr. HINOJOSA. Congresswoman Hooley, I am impressed by the way you describe the MAP program in your district, and also I am impressed by your commitment and passion for this prevention program.

Tell us a little bit about—when you talk with adults and students who are part of this program, what do they tell you about why the program works so well and what could be done to improve it?

Ms. HOOLEY. When I talk to the students, first of all, they are very excited about doing this. They feel like—I mean, first of all, they have had to do the research. They have had to look at pictures like this. They have gone out and talked to addicts. They have talked to people that are in the treatment programs. They have talked to law enforcement.

They have spent a lot of time. Some of these PSAs have taken them a whole year to do. So they have spent a lot of time learning about not only methamphetamines but all drugs. And then they have—it has also given them something to do after school, and we know after-school programs work very well at keeping a lot of kids out of trouble.

And then they are trying to do ads that they think will have an impact on their fellow students. And they are learning a new skill. So it is all of these things rolled into one. Is this the end-all? You know, I do not think so. But does it work? It seems to work.

We are looking at doing a study and evaluating the impact and the effectiveness of this. We have just started. It has only been in progress for about a year. This has only been a 3-year program. It has only been done in, in do not know, six or seven schools.

But it works. And let's take things like that that we know work and expand that. If there are other programs around the country, and I am sure there are, let's take those and expand those. And let's see what really makes an impact.

And let's do follow up, not only the next year and the next year, but several years out and see what has happened and if we have actually made, you know, some progress in preventing students from getting on drugs.

One of the things these ads have done and the documentaries have done is not only just for methamphetamines, but it really works for all drugs. I mean, they have a much greater awareness of the dangers of drugs.

Mr. HINOJOSA. Thank you very much.

Mr. Chairman, my time has run out. I wish I could have asked the question of Congressman Souder.

Mr. SOUDER. May I make a brief comment on that?

Mr. OSBORNE. Yes, why don't you go ahead, Mark?

Mr. SOUDER. A direct challenge of our committee when we do the reauthorization in elementary education—this committee does Safe and Drug-Free Schools. And we, in my opinion, in working on that—I have tried multiple amendments the last time through.

In reaching many allowable use, nice goals, what we have done is taken the best antidrug prevention program in the United States

and had it so frittered down that we have seen a number of studies now showing that this money is not working.

That has resulted in multiple attempts by the administration to zero out this program. And I have been fighting to keep it in. They also try to keep only the national part, because when we break it up by school, often what results is one speaker comes in.

And what we need to be looking at—which is fine. It is better than nothing. But it is not an effective use of the program. And we need in our committee here on education to be looking at what can we do to give some more direction. And I believe part of it is how to leverage money.

And I believe that many schools now have their own little T.V. and radio areas inside the school. They also have posters and announcements. They also can work—often the local broadcasters love to have kids come forth with things they can use as PSAs in the local community.

And we need to be looking internally, because we do the bill in this committee of how can we encourage things and, if necessary, market not exactly what to do, but that this should be part of the component of leveraging the dollars in Safe and Drug-Free Schools in getting the kids involved in addressing kids' issues.

Mr. HINOJOSA. Mr. Souder, do you believe that this part of the education program should be a part of the essential elements of learning in K-12 programs?

Mr. SOUDER. I believe this is an interesting debate that has revolved around character education for many years. Should character education be taught as a separate program, or should it be integrated?

And my position has always been both, that there ought to be some things targeted directly at drugs, but it ought to be integrated in to health classes. It ought to be integrated in to phys-ed classes and physical education classes because of what it does to your body, as we see what is happening with steroids in the United States.

It is just like character education. It ought to be everywhere, but also focused.

Mr. HINOJOSA. Thank you.

I yield back.

Mr. OSBORNE. Well, thank you, and I would like to thank the members of the panel and—sure, all right.

Mr. Davis?

Mr. DAVIS OF ILLINOIS. I just wanted to ask you this one question. I do not know anybody who have spent more time, energy, effort on this than you have. Have you run into any successful—and it is hard to measure success over short periods of time—but good prevention programs targeted specifically for the workplace?

Mr. SOUDER. Not as much, and there is not as much research on workplace. I am sure they exist.

One of my frustrations is we do not really have a good clearinghouse, and it is one of the things I think ONDCP ought to be doing, is serving as a clearinghouse, so when somebody says do I have a workplace program, do I have a school program, do I have a community program, they can go there and look—here is meth, here

is cocaine, here is general—and that we have this clearinghouse type of thing.

There have been some scattered successes for periods of time. For example, drug testing usually works at the workplace to clear your place out, but it does not help the individual. And very few companies want to invest in the treatment that goes with the drug testing, unless, of course, there is low unemployment and then they have an incentive to try to keep their employees there.

Generally speaking, it depends on how you define your goal. Is your goal to eliminate drugs from the workplace? Is your goal to help the individual so you do not just kick them over to another place that does not drug test?

But my feeling is that there has been very little—and I was chairman of the Small Business Empowerment Subcommittee, we did the first drug-free workplace bill in Congress about 10 years or 8 years ago, something like that. And it was a start of how you do drug testing that management needed to be included, not just labor.

It needed to make sure that you had an accurate test, and that you included treatment. Otherwise you were losing your employees and not helping them. You were just shifting in between businesses. That was a pilot program, never went very far, and did not focus, really, on the prevention side. It was more preventing once you found somebody.

My opinion is probably there is a little bit, but both in that subcommittee and since then I have seen very little related to workplace. That is not to say that it is not there, but I have not seen much.

Ms. HOOLEY. Representative Davis, let me—in one of my communities, Salem, Oregon, there is a program that I will—I do not know enough details about it. I will send you the information.

That is a community that has a program that the whole community is working on, Not in My Backyard, and it not only deals with trying to stop the demand and the treatment programs, but the entire community, including the business community, is very, very involved. It is the best community effort I have seen to date.

And again, it may happen in other communities, but I will send you that information.

Mr. SOUDER. Yes, and Cincinnati has had a very successful community-wide—and in southeast Kentucky, but they have not—they include the businesses in it.

For example, in a program that is starting up in my district with the schools, they are not only doing some drug testing. They have brought in the business community to find jobs for kids that are willing to stay clean, who are in high-risk populations and do not have the ability to get a job.

There are combined efforts, but I cannot think of one, and we ought to look inside some of these programs, how they implement it specifically at the workplace.

Mr. OSBORNE. Okay. Well, thank you so much for coming, both of you, and appreciate your work on this issue and your expertise.

And we will call up the second panel at this time and get the appropriate identification. So please have a seat.

Okay, at this time I will introduce the second panel.

Mr. Robert Denniston is presenting for the Honorable Mary Ann Solberg. Mr. Denniston currently serves as the director of the National Youth Anti-Drug Media Campaign at the White House Office of National Drug Control Policy.

Previously, he served as director of the U.S. Department of Health and Human Services' Secretary's Initiative on Youth Substance Abuse Prevention. Prior to that, Mr. Denniston held several positions in the prevention field, including director of the Division of Prevention Application and Education at the Center for Substance Abuse Prevention.

In addition, I want to thank Mr. Denniston for stepping in for Deputy Director Solberg at the last moment.

Someone who is from my district, the Honorable John Icenogle is a district judge and district court judge serving Buffalo County, Nebraska. Judge Icenogle has served as president of the Juvenile Justice Association and, since 1995, has headed the District Judges Education Committee.

Judge Icenogle has a long-term interest in children's issues and is a member of the Nebraska Governor's Children's Task Force.

So we are very pleased to have you here today as well.

And Dr. Richard Spoth is the director of the Partnerships in Prevention Science Institute at Iowa State University, not too far away. And in addition to his current position, Dr. Spoth has a long history of involvement in substance abuse prevention including joining with his colleagues to spearhead the development of a number of other prevention and research-related organizations, including the Institute for Social and Behavioral Research at Iowa State University.

So welcome, Dr. Spoth. We are glad to have you here.

And then the final member of our panel is Ms. Cristi Cain, and she serves as the state coordinator for the Kansas Methamphetamine Prevention Project in Topeka. Prior to her current position, Ms. Cain served in several prevention programs in the Topeka, Kansas region.

In addition to her work experience, she has trained people from all over the country to educate and rehabilitate individuals with drug addictions.

So we want to thank all of you witnesses for your time and your testimony, and also the members for their participation.

And so at this point—I think Mr. Denniston and Mr. Icenogle has to leave before noon, so we will definitely try to get your testimony in, but we will hear from all of you.

So, Mr. Denniston?

STATEMENT OF ROBERT DENNISTON, DIRECTOR, NATIONAL YOUTH ANTI-DRUG MEDIA CAMPAIGN, OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, ON BEHALF OF HON. MARY ANN SOLBERG, DEPUTY DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

Mr. DENNISTON. Chairman Osborne and distinguished members of the committee, I am honored to appear before you today to discuss the key pillar of the president's national drug control strategy, stopping use before it starts, education and community action.

As we know, methamphetamine use can be prevented by a combination of federal, state and local officials and actions and communities. And I am here today on behalf of Mary Ann Solberg, the deputy director of ONDCP, who unfortunately could not be here because of a family emergency.

Deputy Director Solberg's written testimony discusses a number of programs and efforts to stop meth use through prevention and education. And I respectfully request that it be made part of the record.

I serve as director of the ONDCP's National Youth Anti-Drug Media Campaign. As you all know, meth is incredibly dangerous because of its high potential for addiction, its devastating physical and psychological consequences and its harm to communities.

We believe that reducing the demand for meth through prevention will result in less demand for the drug, and this will help drive down production, thereby putting less strain on law enforcement and treatment providers.

Nationally we have worked to support prevention activities through proven initiatives that support state and local efforts. The youth campaign, student drug testing grants, and the drug-free community support program all push back against the negative influences of drugs and now, more than ever, against meth as well.

Now, the National Youth Media Campaign leads our efforts to reduce youth drug use. It is a strategically integrated communications effort that delivers antidrug messages and skills to America's youth, to their parents, and to influential adults.

The youth campaign and the Partnership for a Drug-Free America have partnered to develop new, hard-hitting antimeth ads for television, radio and print. These ads aim to build public understanding of the threat from the manufacture and use of meth and to alert citizens about what they can do to protect themselves and their communities.

We released these ads this week, earlier this week, on Monday, in Springfield, Missouri. Several people were there, including Senator Talent and, of course, ONDCP Director John Walters.

At this point, I would like to show you two of those new ads.

(BEGIN VIDEO CLIP)

GIRL: This is my [inaudible] when my dad and I cooked breakfast together. He always called me his honey. But then he started using the kitchen to make meth. One night, the police came in with white suits and gas masks. I was taken to the hospital and decontaminated. I haven't seen my dad since.

(END VIDEO CLIP)

Mr. DENNISTON. We should have another ad in the series.

(BEGIN VIDEO CLIP)

ANNOUNCER: The toxic fumes from this meth lab are seeping into Jamie's sinus cavity. Ammonia vapors invade her throat. Toxic gases fill her lungs. Jamie's body is deteriorating, and she doesn't even know it.

MOTHER: Jamie? Dinner.

ANNOUNCER: So, who has the drug problem now? Find out how meth affects you at drugfree.org/meth.

(END VIDEO CLIP)

Mr. DENNISTON. These are two of the five ads in the new campaign created, again, by the Partnership for a Drug-Free America for us and they were actually produced by the top-flight ad agencies, Leo Burnett and J. Walter Thompson, so we are very pleased with these ads and are getting them out to communities across the country just as quickly as we can.

We believe by working with Congress, states, local communities and the private and non-profit sectors we hope to show these antimeth ads in every community that suffers from the detrimental effects of methamphetamine.

Now, turning to student drug testing, in addition to the media campaign, random student drug testing is an effective part of a community-based strategy to reduce the demand for illegal drugs including methamphetamine.

The purpose of student drug testing is not to punish kids but, rather, to stop drug use before it starts or in its earliest stages. It serves as an effective deterrent to drug use. Since 2001, we have seen a 25 percent decrease in meth drug use. That is very good news.

And that is part of a reduction of 17 percent in overall illicit drug use by teens the last 3 years. Everyone who has been involved in this whole effort to reduce teen drug use should really be commended. That is a dramatic drop, 17 percent in the last 3 years.

Turning to drug-free communities, the drug-free communities program provides grants to communities that have formed antidrug coalitions that present a united community front in the fight against drug abuse. This program currently funds more than 700 coalitions that seek to form, sustain and evaluate effective efforts to prevent and fight the use of illicit drugs, particularly by youth.

In conclusion, I am pleased to present to you today some of the Federal Government's prevention efforts to stop meth in our communities. Again, thank you, Mr. Chairman. I look forward to any questions the committee may have.

[The prepared statement of Ms. Solberg follows:]

Statement of Hon. Mary Ann Solberg, Deputy Director, Office of National Drug Control Policy, Executive Office of the President, Washington, DC

Chairman Castle, Ranking Member Woolsey, and distinguished Members of the Subcommittee, I am honored to appear before you to discuss the President's National Drug Control Strategy and how the Administration is preventing methamphetamine use across our country.

The President's National Drug Control Strategy aims to reduce use of all drugs in America by 25 percent within five years and recognizes methamphetamine as one of the primary drug threats to America. Within the Strategy are three priorities: 1) stopping drug use before it starts, 2) healing America's drug users, and 3) disrupting the market for illegal drugs.

This balanced strategy is working. Nationally, we have made progress over the last three years against substance abuse. The 2004 Monitoring the Future survey showed a 17 percent decline in youth drug use since 2001. This equates to 600,000 fewer young people using illegal drugs today than were using three years ago. The use of methamphetamine by teenagers has declined even further, with use down 25 percent since 2001. Despite these decreases in use, methamphetamine is still too prevalent across the Nation. In 2004, 1.4 million Americans had used methamphetamine within the past year, and 318,000 of them had tried methamphetamine for the first time. Despite the decrease in teen methamphetamine use, 1.4 percent of twelfth graders in 2004 still said they have used methamphetamine in the past month.

Nationally, drug treatment admissions for methamphetamine/amphetamine dependencies have been increasing. In 2002, nearly seven percent of treatment admis-

sions nationwide were for methamphetamine/amphetamine, up from just one percent in 1992. Similarly, emergency room visits related to methamphetamine/amphetamine use increased 54 percent between 1995 and 2002.

Dangers of Methamphetamine

Methamphetamine is an addictive, synthetic drug that is extremely dangerous both to take and to produce. The use and the manufacture of methamphetamine are twin problems that together are ravaging many communities across the Nation and each presents major challenges at the Federal, state, and local levels.

Methamphetamine has a high potential for abuse and dependence. Methamphetamine abuse can have devastating physical and psychological consequences. The drug causes increased heart rate and blood pressure, and its use has been associated with serious and prolonged brain damage. Over time, many users become badly emaciated from suppressed appetite, and suffer rapid severe tooth decay, and, in the long run, suffer psychosis. Methamphetamine is easy to make and can be manufactured for as little as $50 in supplies, allowing users to manufacture and supply methamphetamine cheaply for their own needs. During the manufacturing process, methamphetamine cooks face exposure to toxic fumes, asphyxiation, and the possibility of serious injury or death due to fire or explosion. These dangers extend to those in close proximity who may not be involved in the process, such as children. Methamphetamine's damage spreads beyond the user and harms the lives of children who grow up around this dangerous drug both because of the chemical exposure as well as the neglect of parents who are high on meth. Across the nation, increasing numbers of children have been sickened by exposure to toxic chemicals used in methamphetamine production while others have been placed in foster care because parents or guardians who abuse methamphetamine are unable to care for them. Methamphetamine labs present environmental challenges, and clean up of the toxic sites is both dangerous and expensive.

Reducing the demand for methamphetamine through prevention will result in less demand for the drug which will help drive down production, thereby putting less strain on the public safety officials and drug treatment providers who deal with methamphetamine's harmful effects.

Prevention programs are varied and often creative, and the National Drug Control Strategy discusses an array of prevention programs—including school and community-based programs such as Meth Watch, student drug testing programs, educational efforts and public service advertisements. Prevention programs may vary widely, but generally are associated with information, education, model behaviors, and early intervention activities. These programs focus on reducing risk factors and building protective factors and may be directed at any segment of the population. Several prevention activities or strategies may be used effectively in combination. Nationally, we have worked to support prevention activities through effective initiatives that support local efforts: the National Youth Anti–Drug Media Campaign, student drug testing grants, and the Drug Free Communities support program.

National Youth Anti–Drug Media Campaign

ONDCP's National Youth Anti–Drug Media Campaign leads our efforts to reduce youth drug use. The Youth Campaign is an integrated effort that combines advertising with public communications outreach. It has developed a series of advertisements that change youth attitudes of drug use and coach parents in monitoring teen behavior and promoting early intervention against signs of early drug use. We are convinced that the Youth Campaign has been a major contributor to our success. This year's results from the Monitoring the Future (MTF) study conducted by the National Institute on Drug Abuse in the Department of Health and Human Services (DHHS), further strengthen the historic reductions observed in last year's results.

Among all three grades surveyed by the MTF over the course of the Youth Campaign, youth report being to a "great extent" or "very great extent" less favorable toward drugs and less likely to use them in the future. Further, more than half of the increase in most of these outcomes among all three grades has occurred in the past three years. This is particularly striking among 10th graders, our primary target audience. With these results, the Youth Campaign will continue as ONDCP's primary drug prevention program, and I look forward to additional progress in the future.

On November 2, ONDCP launched a new, positive, aspirational brand that resonates with the Media Campaign's core target audience of 14–16-year-olds. The "Above the Influence" brand is the result of extensive qualitative and quantitative research ONDCP initiated with teens to ensure the Campaign is speaking with a message and voice relevant to today's youth. The new brand speaks directly to teens at a vulnerable age, when they start to test limits, defy their parents, become more

independent, make their own choices, and assume greater responsibility for their actions. The "Above the Influence" brand empowers teens to recognize and live above peer pressure and negative influences. It squarely addresses the social context that leads to bad decisions, such as drug use. A teen who is "Above the Influence" recognizes the risks of negative influences and is empowered to live above them.

The television, print and internet advertisements, and the Web site, explore a variety of pressures teens face and the positive value of resisting negative influences. All the advertisement executions of the concept were reviewed by dozens of teen focus groups before being selected for production. Brand and behavioral experts were consulted throughout the creative process, and all the television ads were subjected to rigorous quantitative copy-testing before airing. The cumulative research indicates that the "Above the Influence" brand resonates across all segments of the target audience by gender, race, grade, beliefs and attitudes. The Web site, www.AbovetheInfluence.com, includes information and resources, as well as interactive features to aid teens in recognizing and rejecting negative influences including quizzes and games, along with free downloads and blog icons to share with friends.

The campaign has also begun to focus on the dangers of methamphetamine. This past Monday, Director Walters announced in collaboration with the Partnership for a Drug Free America a new advertising campaign targeting the illicit drug methamphetamine. Designed to mobilize individuals and local community groups to reduce methamphetamine use at the local level, the new effort will run in 23 U.S. cities where methamphetamine has a high prevalence.

The ad campaign combines real-life stories of people impacted by methamphetamine with scenarios that depict the unique secondhand threat methamphetamine poses to communities at large. The campaign's two main themes, "So, Who Has the Drug Problem Now?" and "End Meth in Your Town" challenge individuals to learn more about the threats methamphetamine poses to both their families and their communities. The advertising campaigns were created pro bono for the Partnership by two agencies, Leo Burnett of Chicago and J. Walter Thompson of New York. Developed under the direction of the Partnership for a Drug–Free America, the research-based campaigns were subject to rigorous qualitative testing, and proved resonant among community members, spurring them to seek information on methamphetamine and to take part in their community's efforts to fight the drug. All advertising spots direct audiences to a newly-created microsite on the Partnership's Web site, www.drugfree.org/meth.

In addition to the new Above the Influence brand, the Media Campaign continues to support parents through the development of a series of advertisements that coach parents in monitoring teen behavior and promote early intervention against signs of early drug use.

The National Youth Anti–Drug Media Campaign will also host roundtables around the country with members of the news media and representatives from the entertainment industry. Experts on various aspects of methamphetamine production, addiction and treatment will be invited to discuss the dangers of the drug and answer questions on the Administration's approach.

Student Drug Testing

In addition to the Media Campaign, another promising prevention practice is random student drug testing. Over three years have passed since the U.S. Supreme Court upheld the authority of public schools to test students involved in extracurricular activities for illegal drugs, making this powerful tool available to any school battling a drug problem. Since that historic ruling, a number of schools across the country have seized this opportunity to implement drug testing programs of their own.

As the President stated in his 2004 State of the Union address, drug testing has proven to be an effective part of a community-based strategy to reduce demand for illegal drugs. Student drug testing is an excellent means of protecting kids from a behavior that destroys bodies and minds, impedes academic performance, and creates barriers to success and happiness, and it is available to any school, public or private, that understands the devastation of drug use and is determined to confront it. Many schools urgently need effective ways to reinforce their anti-drug efforts. Drug testing can help them.

Indeed, student drug testing is that rare tool that makes all other prevention efforts more effective. By giving students who do not want to use drugs an "out," testing reduces the impact of peer pressure. By giving students who are tempted by drugs a concrete reason not to use them, testing amplifies the force of prevention messages. And, by identifying students who are using illegal drugs, testing supports

parental monitoring and enables treatment specialists to direct early intervention techniques where they are needed.

Schools considering adding a testing program to their prevention efforts will find reassurance in knowing that drug testing can be done effectively and compassionately. The purpose of testing, after all, is not to punish students that use drugs, but to prevent use in the first place, and to make sure users get the help they need to stop placing themselves and their friends at risk. Random drug testing is not a substitute for all our other efforts to reduce drug use by young people, but it does make those efforts work better.

Drug Free Communities

Experience has taught us that people at the local level often know best how to deal with drug problems in their own communities. But to combat the threat, they need good information and the best resources available. One way that the Administration is helping to provide them with these resources is with the Drug Free Communities support program (DFC).

The Drug Free Communities program, run through ONDCP and administered through the Substance Abuse and Mental Health Services Administration (SAMHSA), provides grants of up to $100,000 per year to communities that come together to form community anti-drug coalitions that present a united community front in the fight against drug use. The program has two major goals: (1) reduce substance abuse, including alcohol, tobacco, and drugs among youth (2) strengthen collaboration among various sectors in the community.

DFC coalitions are required to include members from different parts of the community working on multiple community drug prevention strategies. Community coalitions catalyze civic action and serve to connect individuals from such disparate parts of the community as health care, law enforcement, business, drug treatment, and education. The Drug Free Communities support program funds over 700 of these coalitions that seek to form and sustain effective efforts to fight the use of illegal drugs, particularly by youth. Coalitions host activities such as town hall meetings on drug issues, youth summits, local drug use surveys, beverage server training, youth leadership training, social marketing campaigns, and policy change.

Many of these coalitions are in rural areas where methamphetamine use is a particular problem. Coalitions in these areas have been working to change the social norms as they are confronted with the dangers of methamphetamine. For example, some coalitions in Oregon are working with stores to increase awareness about the supplies needed by methamphetamine cooks to make the drug, making it harder for methamphetamine producers to set up shop in their area. They are also working with young people to help them understand the dangers of using methamphetamine. Through education and prevention, they are making a difference and are acting as the first line of defense against methamphetamine and other dangerous drugs.

Other Programs

ONDCP and the Bureau of Justice Assistance (BJA) have also recently launched a new website, www.methresources.gov, as a tool for policymakers, law enforcement officials, treatment and prevention professionals, businesses and retailers, and anti-drug activists. The comprehensive site brings together information and resources available to communities on the topic of methamphetamine. The website also enables visitors to share information and best practices with one another, as well as pose questions to their peers.

One methamphetamine specific prevention program that the retail industry has fostered and ONDCP has supported is "Meth Watch." This innovative and voluntary program trains employees in retail establishments that sell key precursor chemicals such as pseudoephedrine to watch for unusual patterns or behaviors that "meth cooks" might display such as buying large quantities of these chemicals or returning frequently to buy the same chemicals. The retailers refuse to sell the products and law enforcement is notified so that they can investigate and determine whether the intended purchases are part of a methamphetamine lab operation. This is particularly important in states that do not have any controls over the sales of precursor chemicals.

Conclusion

I have discussed a variety of prevention programs, including school- and community-based programs, student drug testing programs, and public service advertisements. These diverse approaches help parents keep kids away from alcohol and dangerous drugs like methamphetamine and marijuana. Yet none of these programs is enough to make a decisive difference without significant parental involvement—and for good reason. Available research is unambiguous about the importance of having parents discuss the dangers of illegal drugs and underage drinking with their chil-

dren. Parents and other caregivers need to do more than simply talk about drugs and alcohol. They also need to act by monitoring the behavior of teen children, knowing where their teenagers are at all times, particularly after school, and knowing whom they are with and what they are doing. Such techniques have proved remarkably effective in keeping teenagers away from drugs.

The good news is that parental monitoring has been shown to be remarkably effective in reducing a range of risky behaviors among young people. Studies indicate that kids who are monitored are one-fourth as likely to use illegal drugs and one-half as likely to smoke cigarettes as kids who are not monitored. Put another way, the research confirms what many parents of teenagers tend to doubt: kids really do listen to their parents, and they do respond to parental expectations. For example, surveys show that two-thirds of youth ages 13 to 17 say losing their parents" respect is one of the main reasons they do not smoke marijuana or use other drugs.

In conclusion, I am pleased to present to you today the Federal government's cooperative efforts to stop methamphetamine in our communities. Within the context of our National Drug Control Strategy, we know that reducing all drug use including methamphetamine use will require a balanced consistent, and coordinated focus from all sectors of the community, including the Federal, state, and local government. With the continued support of Federal, state, and local leaders, and concerned citizens everywhere, we are moving closer to creating an America that is free from dangerous drugs such as methamphetamine.

Mr. OSBORNE. Thank you very much, Mr. Denniston. Thank you for being here.

And Judge Icenogle?

STATEMENT OF HON. JOHN ICENOGLE, DISTRICT JUDGE, DISTRICT 9, BUFFALO COUNTY, NE

Mr. ICENOGLE. It is a privilege. Thank you. It is a privilege for me to be here today. I have been a judge in central Nebraska for almost 30 years, and I have been doing the last 16 years general jurisdiction work which includes criminal courts, divorces, child welfare cases, and drug court.

And I took this opportunity to come and visit with you about my observations about what meth is doing within the communities and what it is doing to children.

I am not an expert in law enforcement, and I am not an expert in drug treatment programs, and I am not an expert in prevention programs. And most of my colleagues will tell you that I am probably not an expert in law either.

But that aside, methamphetamine in our communities has a devastating effect on all of our children, and not just the children who become users directly. We see the prevalence of cooking meth in homes. And when you cook meth, you do it in what they call a lab or a kitchen. That kitchen can be in the trunk of a car, garage, outside in a shed or, most likely, they cook in the kitchen.

Meth labs, when they go awry, blow up. People are burned, and burned severely. Fumes are admitted and people can die. There is a reason that law enforcement wears the gear and garb that they do when they go into clean up a meth lab, and that is to avoid being exposed to the same environment children within that home are being exposed to daily.

The use and manufacture of methamphetamine leaves a residue in the home. Blankets, clothing, toys, teddy bears have all tested positive for the presence of methamphetamine, thereby exposing the children in those homes to the risk of long-term physical injury and mental damage.

The toxin involved causes medical problems, including anemia, respiratory illness, neurological symptoms in the child, and those toxins have also been linked with developmental delay and brain damage.

The parents in the home who use the meth create a second and probably more dangerous threat to the children by being their parents. The addicts who are entrusted with the care of these children display post-use behaviors that include violence, paranoia, hallucination, agitation and schizophrenic-like symptoms.

They suffer from cognitive impairments, such as memory loss, confusion, insomnia, depression and boredom. The cognitive impairments often cause the users to misinterpret what other people are saying to them, which results in violent, paranoid reactions. The net result is that the children are suffering gross abuse and neglect in these homes.

When the meth addict finally comes down off the drug and crashes, that addict sleeps, sometimes for 3 to 5 days. The children in that home are often left unfed, unsupervised and, perhaps worse, placed in the care or the whims of their drug-using friends and buddies of the parents.

When the parents awaken, they suffer from depression, heightened cravings for more, and even suicidal ideation. Throughout this period of time, these are these children's parents.

The children are also victimized by the environment that we see in meth homes. They are victims and witnesses of significant domestic violence, physical abuse, and methamphetamine is in a culture that is, quite frankly, sexually explicit.

More than one law enforcement officer has marveled to me that every meth home seems to lack the basic essentials to take care of the children, but they all have a large-screen T.V. and an ongoing supply of pornographic videos.

The children continue to be exposed to a culture of alcohol use and drug use as the friends of the users—parents—come and go. In Nebraska, we have 1.7 million people. Currently almost 6,000 children are placed out of home with the Department of Health and Human Services. Over half of those children are placed—or 62 percent, actually, for non-alcohol substance abuse problems of the parents, mostly identified as methamphetamine.

Recently, in Lancaster County, which is the county our state capital, in a 2-week period, nine juvenile petitions were filed for children born from parents or a mother who had a significant meth problem and therefore the new child had a significant meth problem as well.

We have seen the cost, and the cost is tremendous, whether it is prisons, whether it is welfare, whether it is medical. And I have outlined some of that in my testimony that I submitted in writing.

What I do know is this. If we can take drug courts and spend $1 and get a return in savings of $9, which is just uniform across the country, what kind of return can we get by preventative education? To me, the dollar savings would be tremendous. But from our perspective, and my selfish perspective, the saving in human misery would be so much greater.

These children deserve better. They deserve a chance. I quote one real quick story and why I think prevention is necessary. I had

a young lady who came into my drug court. She had four children who had been removed from her home. She had no job, no family support and an addiction.

Two and a half years later, she came out of drug court. She had her children back. She had a job. She had gotten her other extended family back and was doing really well. Six months later, after leaving the drug court program, she had her meth back, had lost her children and did not have a job. It is a drug that is best confronted before it is used.

And I thank you.

[The prepared statement of Mr. Icenogle follows:]

Statement of Hon. John Icenogle, District Court Judge, 9th Judicial District of Nebraska, Buffalo County, NE

Chairman Castle, Ranking Member Woolsey, and members of the committee, I want to thank you for the opportunity to testify about the issues arising from the production and use of methamphetamine and its effects on the children of Nebraska, especially rural Nebraska. My name is John Icenogle and I have served the last 30 years as a state court judge of general jurisdiction. Initially I served as a state county judge with juvenile court jurisdiction. For the last 16 years I have presided over cases involving domestic disputes, divorce, child custody, criminal law, civil law, and during the last three years have also served as a drug court judge. I am not an expert concerning drug treatment programs, law enforcement, or even prevention programs. I appear here to share with you some of my knowledge and experience regarding the effects of methamphetamine on children and their families within our communities.

The manufacture and use of the highly addictive stimulate, methamphetamine (meth), has grown exponentially over the last 25 years gaining a strong and lethal foothold throughout the midwest and southwestern United States. The very nature of the drug victimizes not only the addicts but often the children within their care.

The drug is relatively cheap to purchase on the street, and can be made inexpensively at home following recipes available on the internet. "Cooking" meth is almost as easy as baking a chocolate cake. One of the simplest recipes requires the use of anhydrous ammonia which is in agricultural areas. Laboratories easily fit into car trunks, hotel rooms, garages, and home kitchens.

The labs themselves are extremely dangerous to persons, frequently children, within their proximity. The "cooking" process involves a substantial risk of explosion and produces fumes which can be fatal. In my own jurisdiction, a rural county of some 45,000 persons, law enforcement has uncovered several meth labs. One was operated by a counselor employed by our own youth rehabilitation center. He was cooking methamphetamine in the garage of his children's home.

The use and manufacture of methamphetamine leaves a residue of the drug throughout the home. Blankets, clothing, children's toys and even teddy bears have tested positive for the presence of methamphetamine thereby exposing children to the risk of long term physical injury and mental damage. The toxins involved cause medical problems including anemia, respiratory illness and neurological symptoms in children. They have also been linked to developmental delay and brain damage.

Parental use of methamphetamine creates a second and even more dangerous threat to children because of the drug's immediate and long term effects on the user. Addicts entrusted with the care of children display post-use behaviors that may include violence, paranoia, hallucinations, agitation and schizophrenic-like symptoms. Users suffer cognitive impairments such as memory loss, confusion, insomnia, depression and boredom. The cognitive impairments often cause users to misinterpret body language and words resulting in violent paranoid reactions to perceived threats. This neurological damage and psychotic behavior can persist months and even years after use is discontinued and often results in children suffering gross abuse and neglect.

When a meth addict stops using the drug, the addict's body often "crashes" seeking sleep. Addicts often sleep from three to five days leaving their children unfed, unbathed, unsupervised and often in the "care" or at the whims of their drug using buddies. Upon awakening, the addict may suffer from severe depression, heightened cravings or suicidal ideations. Throughout all of this, the meth addict is still "parenting" the children.

The children in a meth home are also victimized by the very environment in which they live. They are victims of, or witnesses to, significant domestic violence and physical abuse. The methamphetamine culture is often sexually explicit. More than one law enforcement officer has marveled that almost every meth home he has entered lacked the basic essentials for the care of children, but contained a large screen tv and ample supplies of pornographic videos. The children in a meth home are exposed to both an alcohol and a drug culture as friends of the users come and go. Children tend to isolate themselves from other children and have high truancy rates from school.

Children living in an identified meth home are also victimized by the necessity of being removed from their home environment. In April, 2005, 5852 children were living in out-of-home placements within the State of Nebraska (a state with a population of only 1.7 million people). Sixty-two percent of the parents from whom children are removed suffer from non-alcohol substance abuse and more than one-half of those have problems primarily due to use of methamphetamine. During a recent two week period in Lancaster County, the home county for our state capitol, the county attorney filed juvenile petitions on behalf of nine newborns because of methamphetamine use by the mothers. In the Omaha area, the county attorney's office estimated that at least 50% of the children currently entering the state's social service system enter because of methamphetamine use.

Even when identified, meth homes are not quickly fixed. Mom's required to choose reunification with their children or continued meth usage, all too often choose their drugs rather than their children. One Nebraska judge has estimated that in abuse or neglect cases involving methamphetamine addicted parents, intervention in his county has been successful only 20% of the time. I personally observed one young mother enter our drug court program addicted, without family support, without employment, and having just lost custody of her four children. After two and one-half years in the drug court program, she obtained sobriety, became self-supporting, and gained custody of her children. Within six months after completing the program, she again started to use meth and has lost custody of the children. Although the tale is tragic for the mother, it is more tragic for her children.

One must be mindful that children are not only the innocent victims of methamphetamine users within their family or their community, they all too often will become users themselves. For some, methamphetamine offers a method of weight control, sexual adventure and peer acceptance. When children become users, successful redirection of their lives and successful treatment interventions are far more problematic than for adults.

As a society we all agree that these children need protection. We have spent millions of dollars for enforcement of criminal laws, millions of dollars for foster care and programs for the child victims. We have spent too few dollars for treatment programs for users. We have spent virtually nothing on prevention efforts.

We recognize the collateral cost of addiction in caring for the children of addicts. Additional birthing expenses for a meth mother include as much as $1500.00 to $25,000.00 per day for the care of her child. Low birth weights caused by meth use necessitate neonatal care of some $25,000.00 to $35,000.00. Some children require nearly a quarter of a million dollars in care to ensure the child attains the age of one. The developmentally delayed children can require up to three quarters of a million dollars in special care during the child's first 18 years of life.

The cost of addressing the problem of methamphetamine use is staggering and increasing. One wonders what the dollar savings could be if we create an effective prevention program. More importantly, one wonders how much human misery could be eliminated, especially for children, if we address and support effective use prevention programs.

I want to thank this committee for the opportunity to visit with you today and will gladly answer any questions that you might have.

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Mr. OSBORNE. Thank you very much, Judge. I have been at a couple of your drug court graduations and you do a good job, and we appreciate it very much.

Dr. Spoth?

STATEMENT OF DR. RICHARD SPOTH, PH.D., DIRECTOR, PARTNERSHIPS IN PREVENTION SCIENCE INSTITUTE, IOWA STATE UNIVERSITY, AMES, IA

Mr. SPOTH. Chairman Osborne and members of the subcommittee, thank you for inviting me to represent the Partnerships in Prevention Science Institute at Iowa State University in this critically important hearing on substance abuse prevention with a special focus on methamphetamine abuse.

As a research institute focused on prevention science, most of our work involves experimental studies that evaluate outcomes of preventative interventions for youth and families. I am here to address a number of questions about our work.

The first one is what are our methamphetamine-related results. Research at our institute has found that interventions delivered through our partnerships with schools and communities have revealed significant effects on lifetime or past-year methamphetamine use, up to 6.5 years after the baseline assessment in these studies.

Results from two of our longitudinal studies are summarized in this slide. For example, 11th graders in study two who participated in a combination of school-based and family-focused interventions reported 64 percent less lifetime meth use than youth who do not participate in the interventions.

Second question: What is our science with practice approach to prevention? There are five key elements to our approach. The first is a linkage of existing state public education systems, ones that have infrastructure for optimal delivery and evaluation of interventions with other service or resource systems.

This includes public schools and the cooperative extension system based in land grant universities. This system serves a purpose of disseminating research-based information and programming to the general public. It is the largest informal education system in the world. It has over 3,150 agents at last count and a presence in nearly every county in every state.

A second feature is strategic partnerships. This slide shows our current three-tier partnership structure that helps us move our scientifically tested evidence-based interventions from the university out into the schools and communities in the state that can benefit from them.

To date, our projects have partnered with 106 public schools long term, and many others short term. Our local teams are small and strategic. They select interventions from an intervention menu and handle all logistics involved with their implementation.

A prevention coordinator team provides continuous proactive technical assistance to those local teams. A university prevention team provides administrative oversight and offers input on data

collection and analysis. Currently we are implementing this model on a project called Prosper with our colleagues at Pennsylvania State University.

Concerning evidence-based interventions, the Society for Prevention Research has summarized standards for them. In a word, they are theory-based. They have clear objectives. They are rigorously tested and show positive outcomes. Hereafter, I will label them EBIs for short.

One of the key advantages of EBIs is that positive outcomes and economic benefits are more likely for youths and families and others.

Number three, the reason for emphasis on quality implementation is that numerous studies have shown that over time intervention implementation tends to drift away from the quality necessary to produce positive program outcomes.

Number five, we also place a premium on sustainability planning, because research suggests that one of the major barriers to public health impact of evidence-based interventions is a failure to sustain programmatic efforts, particularly when the activities are initially funded through time-limited grants.

The third question is what is the evidence that our approach works in general. Many positive outcomes from six randomized controlled studies and 11 supplemental studies have shown effective partnership processes and positive long-term outcomes.

I will share two additional examples. To illustrate positive longitudinal outcomes in addition to those concerning methamphetamine use, in one of our studies we examined rates of substance initiation from 6th grade through 12th grade.

Analyses demonstrated statistically significant differences in the rate of growth for the substance use between our family-focused intervention group, the blue line, and the control group, represented by the red line.

Results concerning lifetime drunkenness are shown in this slide. Importantly, research at our institute and that of others has demonstrated the economic benefits of these positive substance prevention outcomes.

This figure shows the estimated return for each dollar invested in a family-focused evidence-based intervention under actual study conditions, an estimated return of $9.60 for every dollar invested. The figure also shows expected changes in the dollars returned when the number of adult alcohol use disorders prevented per 100 participants is increased by and decreased by one.

The last question that I will answer is how can this kind of approach, our approach, help to address larger-scale prevention impact. First, we need to rise to the many challenges. Our partnership model is designed for dissemination to other states. There are, however, some major challenges to scaling up this and any other approach.

First, we need to increase the number of evidence-based interventions to serve youth and their families in a culturally competent way across all settings and all stages of youth development.

Second, we need to gradually change our delivery systems so that they can sustain large-scale quality implementation of evidence-

based intervention. A large number of states have already expressed interest in adopting our partnership model.

Scaling up for widespread dissemination requires, number one, a set of state-focused replication plans to gradually bring our partnership model to additional states, to address a range of youth development and problem behavior areas where evidence-based interventions could help; and two, the development of infrastructure to support a network for new partnerships, including information materials, technical assistance and a structure for partnership networking.

In short, to hearken to the words that we heard earlier, we believe in an investment in the type of partnership approach outlined above would save money, do substance-related problems, and improve youth and family health and well-being, making a real world difference.

Thank you, and I would be happy to answer any questions that you have.

[The prepared statement of Mr. Spoth follows:]

Statement of Dr. Richard Spoth, PhD, Director, Partnerships in Prevention Science Institute, Iowa State University, Ames, IA

Introduction

Mr. Chairman and members of the Subcommittee: Thank you for inviting me to represent the Partnerships in Prevention Science Institute at Iowa State University in this critically important hearing on substance abuse prevention, with its special focus on methamphetamine abuse. As a research institute focused on prevention science, most of our work involves experimental studies that evaluate the outcomes of preventive interventions for youth and families. A unique aspect of our program of research is its model of school-community-university partnerships that implement the interventions and help sustain preventive efforts over time.

As I understand it, my task today is to respond to questions concerning our methamphetamine-related findings, how we approach methamphetamine and other types of substance abuse prevention, the evidence we have that our approach works in general, and how our approach can help to address the challenge of large-scale prevention impact. I am pleased to do this.

If I were to respond to this task with one sentence it would be: The effort to achieve larger-scale impact is very complex and challenging, but there has been much progress and some promising future directions are clear. Responses to the questions I have been asked to address will serve to highlight these points.

I. What are some illustrative methamphetamine-related results from our prevention work?

A. Short answer: Our randomized, controlled studies have shown intervention effects as long as 6½ years past the baseline assessment.

B. More detailed answer. To begin with some background information on our prevention work, our university motto "science with practice" captures the central theme of our Institute promoting the application and translation of intervention science into community practices, to improve people's health and well-being.

Our Institute's mission is: "To conduct innovative research promoting capable and healthy youth, adults, families, and communities through partnerships that integrate science with practice." Almost all of our work has been funded through grants from the National Institutes of Health, the National Institute of Mental Health, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, with the lion's share of the funding coming from the latter. We also have received funding from the Center for Substance Abuse Prevention in the Services Administration for Mental Health and Substance Abuse.

In pursuit of this mission we have three primary goals.

1. To study the effects of prevention and health promotion interventions for youth, adults, families, and communities;

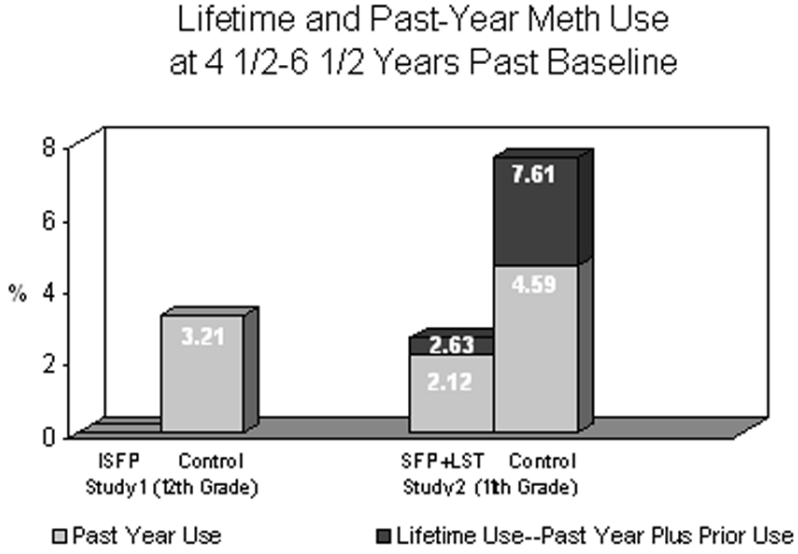
2. To examine factors influencing youth, adult, and family involvement in evidence-based prevention, health promotion interventions, and intervention research projects; and

3. To evaluate the quality and sustainability of community-school-university partnerships and partnership networks, for widespread implementation of evidence-based prevention, positive youth development, and health promotion interventions.

To address our first goal we have designed and conducted a number of preventive intervention outcome studies. Motivated by the findings of epidemiological research on increasing rates of methamphetamine use among adolescents, we added meth-specific outcome measures on two of our long-running preventive intervention studies. As you know, dramatic increases in use among adolescents have been seen; the 2003 prevalence rates are almost five times higher than the rates in 1992 (Johnston, O Malley, Bachman, & Schulenberg, 2004; Oetting et al., 2000). Researchers have noted that adolescents in smaller towns and rural areas are particularly vulnerable to methamphetamine use, given the potentially powerful peer influences in rural environments and the historical appeal of stimulants to rural youth (Wermuth, 2000). The threat to rural Midwestern adolescents has been particularly acute (Rawson, Anglin, & Ling, 2002; Hall & Broderick, 1991; National Clearinghouse on Drug and Alcohol Information, 1997).

Our analyses of interventions delivered via community-university partnerships have revealed significant effects on lifetime or past-year methamphetamine use, up to 6.5 years after a baseline assessment. There also are some positive results from a third study, based on results from data collected at 1.5 years past baseline.

The following graph illustrates intervention effects on methamphetamine use (Spoth, Clair, Shin, & Redmond, 2005). Another way of describing the results from eleventh graders in Study 2 is as follows: eleventh graders who participated in both school-based and family-focused interventions reported 64% less lifetime meth use than students who did not participate in the programs.



Note: ISFP is the Iowa Strengthening Families Program; SFP + LST is the Strengthening Families Program (revised ISFP) plus Life Skills Training

II. What is our "science with practice" approach to prevention? A. Short answer: A science-driven partnership network linking public schools, Land Grant Universities and other resource systems.

B. More detailed answer: There are five key elements in our approach:

1. Linkage of existing, stable public education systems—ones that have infrastructure for optimal delivery and evaluation of interventions—with other service or resource systems;

2. Strategic partnerships with ongoing, hands-on technical assistance, including direct support from scientists or evaluators;

3. Evidence-based interventions for positive outcomes and economic benefits;

4. Quality implementation of evidence-based interventions for optimizing outcomes; and

5. Sustainability planning model for long-term local buy-in and funding.

1. Linkage of existing, stable public education systems—ones that have infrastructure for optimal delivery and evaluation of interventions—with other service or resource systems.

About 15 years ago we began the first in a series of large-scale experimental studies. At that point we saw tremendous potential in the linkage of public education intervention delivery systems—the State Land Grant University System and the Public School System and linking them, in turn, with other community service delivery systems. In large measure, we saw the potential of their existing capacity for intervention delivery and for partnering in intervention research. To highlight this capacity, I will mention a few salient features of public education delivery systems.

The Cooperative Extension System is: the largest informal education system in the world; has over 3,150 agents in nearly every county that are highly educated; and has a "science with practice" orientation. The Public School System is a universal program delivery system reaching nearly all children; it has networks within each state for programming support and has increasing emphasis on accountability, as well as an empirical orientation.

For those of you who are less familiar with the Land Grant University and the Extension System, the Morrill Act of 1862 and the Hatch Act of 1887 established the U.S. Department of Agriculture and granted land in each state to support a college for teaching agriculture and engineering, as well as establishing agricultural experiment stations to conduct research. The Extension system soon followed, to carry the practical and relevant education to ordinary citizens through an extensive network of state, regional, and county extension offices in every U.S. state and territory. Its mission is: "To advance knowledge for agriculture, the environment, human health and well-being, and communities by supporting research, education, and extension programs in the Land–Grant University System and other partner organizations." Extension is uniquely funded by a combination of federal, state, and county government monies.

Our framework is designed to seize the opportunity for intervention delivery in the existing public education systems. We do so by following Everett Rogers" (1995) "linking agents" concept from his Diffusion of Innovation Theory. That is, we emphasize the role of Land Grant University Extension agents who link public school personnel who are aiming to implement tested, proven programs for their students and families, with systems of external services and resources, to promote health and well-being among youth and families.

In sum, linking public schools with the Land Grant Extension System and with other social and human services facilitates our efforts by helping PPSI to:

a. Deliver evidence-based interventions that have the greatest likelihood of producing favorable individual- and community-level outcomes;

b. Have the potential to reach every community across the U.S.;

c. Focus on community capacity-building and sustainability, so that chosen interventions will continue to be implemented over time; and

d. Develop and maintain ongoing partnerships, to which I will turn next.

2. Strategic partnerships with ongoing, hands-on technical assistance, including direct support from scientists or evaluators.

Over the 15 years our projects have entailed partnering with 106 public schools on a long-term basis and many others on a short-term basis. Over the course of the last 15 years, our partnership model has evolved. To begin, our evaluation of community-based interventions had an initial community-university partnership structure for collaborative research and program implementation. In a study called Project Family Trial I, we collaborated with local Extension agents early in the process to help coordinate with local public school staff and program facilitators who, in turn, closely communicated with university partners to implement and evaluate our preventive interventions. This led to a second generation partnership structure employed in another earlier project, namely the "Capable Families and Youth" Project, where we learned how helpful it was to involve Extension staff who acted as linking agents at the state/regional level and assisted in coordinating our intensive program implementation and evaluation work across communities. The second generation partnership added a loosely-knit group of community residents who helped with organization and implementation of the intervention, but did not function as a team committed to long-term implementation (e.g., with regularly scheduled meetings and decision-making capabilities concerning implementation).

Inspired by the successes of the first two generations of partnership projects, we co-hosted a conference about Extension-assisted research projects (Spoth, 1998) that led to the design for the third generation of community partnerships. A salient, somewhat unique feature of the third generation is the relatively small size of the community partnerships, compared with so-called "big tent" community coalitions. These teams are designed to be very strategic, with focused intervention goals, and

the responsibility to select interventions to implement locally (both family-focused and school-based) from an intervention menu.

The organizational structure for the third generation partnership model is outlined in Figure 1. Three teams form the model.

a. Local Strategic Teams:

• Are comprised of Extension System staff who serve as linking agents between public school system and other service or resource systems, such as health and social service provider organizations, as well as other local community stakeholders, including parent groups, and youth groups;
• Meet regularly to plan activities/review progress;
• Select interventions from an intervention menu;
• Recruit participants for family-focused interventions;
• Hire and supervise program implementers;
• Handle all logistics involved with program implementation;
• Market the partnership model in their communities; and
• Locate resources for sustaining programs after grant funding ends.

A Prevention Coordinator Team:

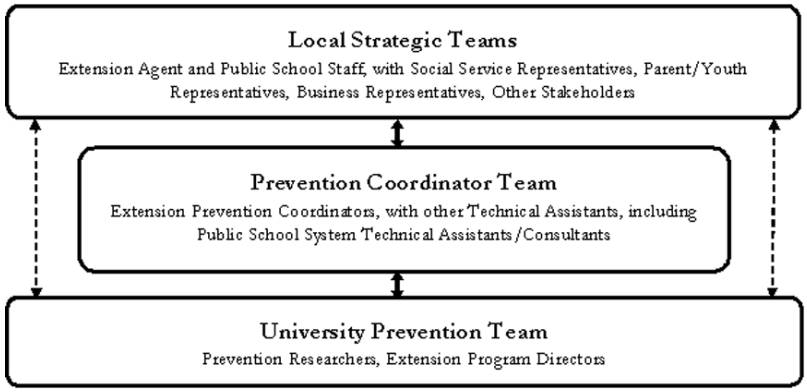
• Includes prevention coordinators based in university outreach or Extension system;
• Provides support to local teams; and
• Provides ongoing, hands-on technical assistance, as well as documentation of ongoing partnership processes.

A University Prevention Team:

• Includes prevention scientists and Extension Program Directors;
• Provides resources and support to both local and prevention coordinating teams; and
• Provides administrative oversight, offers input on data collection and analyses, and drafts project reports.

There are three phases of team development. During the first phase, team members are selected, regular meetings are scheduled, and the team begins to plan intervention work. While in the second "operations" phase, the teams learn about evidence-based interventions on the menu, consider their local community needs, select family-focused and school-based interventions, recruit for the family interventions, and implement both types of interventions. During the third phase, teams develop plans for sustaining their team and their selected interventions; subsequently the team implements sustainability plans (including marketing their efforts and generating resources) and monitors its progress.

Organizational Structure for Community–School–University Partnership Model
(Across three phases of organization, operations, and sustainability)



Currently, we are implementing this model on a project called PROSPER (PROmoting School-community-university Partnerships to Enhance Resilience) conducted in collaboration with our colleagues at Pennsylvania State University.

3. Evidence-based interventions for positive outcomes and economic benefits.

The Society for Prevention Research has summarized standards for classifying interventions as evidence-based. By those standards, evidence-based interventions, or EBIs, are those interventions that: (a) emphasize a strong theory base; (b) clearly specify target populations and outcomes; (c) use psychometrically sound measurement of outcomes; and (d) are supported by rigorous evaluation of outcomes, preferably randomized, controlled studies. The advantages of EBIs are:

a. Positive outcomes and economic benefits more likely for youth, families and others;

b. Better accountability—resources not used for ineffective programs;

c. Potentially better access to funding that is increasingly restricted to EBIs; and

d. Availability of materials, training and technical assistance.

Our focus has been on the partnership-based implementation of EBIs designed for general community populations. These EBIs aim to positively influence the two most important socializing environments for youth; namely, family and school. Extensive research has shown that key causal factors for substance abuse originate in the family and/or school environments, including parenting skills (e.g., parent-child communication, warmth, consistent discipline, and monitoring of child activities) and youth skills (e.g., social competence, decision-making, assertiveness, and substance refusal skills). EBIs included in Institute projects aim to influence these causal factors. Two examples follow.

A family-focused EBI we have evaluated extensively, the Strengthening Families Program: For Parents and Youth 10–14 (formerly the Iowa Strengthening Families Program), is based upon theory and empirical research (DeMarsh & Kumpfer, 1986; Kumpfer, Molgaard, & Spoth, 1996; Molgaard, Spoth, & Redmond, 2000). Goals include the enhancement of parental skills in nurturing, limit-setting, and communication, as well as a range of youth competencies, including peer resistance skills. Skills are taught to both parents and their young adolescent by trained facilitators during seven consecutive weekly sessions. Each session includes a separate, concurrent one-hour parent and youth skills-building curriculum, followed by a one-hour family curriculum during which parents and youth practice skills learned in their separate sessions. Sessions use discussions, skill-building activities, videotapes that model positive behavior, and games designed to build skills and strengthen positive interactions among family members.

A school-based EBI we have evaluated, the Life Skills Training Program, was developed at Cornell University by Gilbert Botvin and his colleagues (Botvin, 1996, 2000), and is theory-based (Bandura, 1977; Jessor & Jessor, 1977). It consists of several lessons taught to adolescents during middle school. The primary programmatic goals are to promote skill development (e.g., social resistance, self-management, and general social skills) and to provide a knowledge base concerning the avoidance of substance use. Students are trained in the various skills through the use of interactive teaching techniques, including coaching, facilitating, role modeling, feedback, and reinforcement, plus homework exercises and out-of-class behavioral rehearsal.

It is very important to note that all of the EBIs we have implemented and evaluated aim to prevent all substance use and do not focus on any one substance in particular; however, we do subscribe to the idea that if there is a delay in initiation of alcohol use (the substance of choice among rural youth), that delay will help prevent the use or abuse of more serious substances, like methamphetamines.

4. Quality Implementation of evidence-based interventions for positive outcomes and economic benefits.

Many prevention efforts fail because of the common misperception that effective EBIs can be easily implemented, but the relevant literature indicates this is seldom the case (Backer, 2003; Fixen et al., 2005; Greenberg et al., 2000). Furthermore, numerous studies have shown that program implementation tends to drift away from the quality necessary to produce positive program outcomes. Implementing effective programs is difficult work, and requires careful, ongoing evaluation of the effectiveness of the implementation process. Our school-community-university partnerships work hard to maintain a high quality of program implementation. To accomplish this goal, our partnerships engage in problem-solving, resource generation, and applying research findings to increase implementation effectiveness. Our data, from trained observers of the implementation process, consistently show high-quality implementation.

5. Sustainability planning model for long-term local buy-in and funding.

Research suggests that one of the major barriers to public health impact of EBIs is the failure to sustain programmatic efforts, particularly when the activities are initially funded through time-limited grants. Central to our partnership approach is a strategic sustainability planning model that begins early in the process. Our partnerships emphasize sustainability of both a well-functioning community team and of continued, quality implementation of EBIs, with emphasis on the generation of local financial and human resources. We are pleased that by the fourth year of our PROSPER project, sustainability planning has resulted in 100% of communities obtaining at least partial funding to continue programming.

III. What is the evidence that our approach works in general? A. Short answer: Six randomized, controlled studies and 11 supplemental studies over 15 years have shown effective partnership processes and positive long-term outcomes on substance

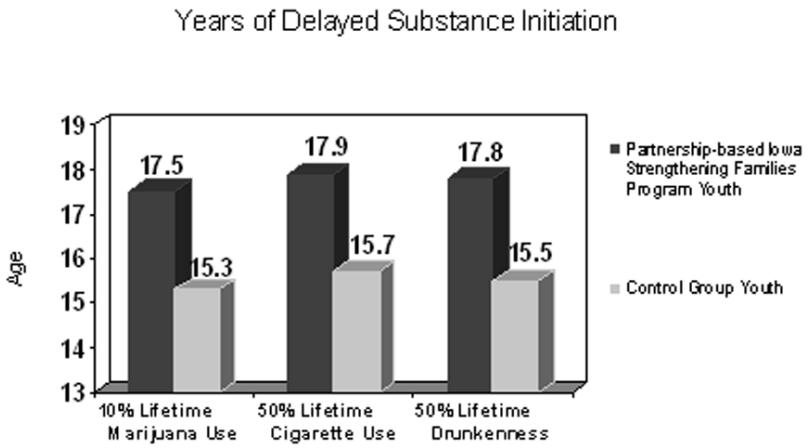
use, problem behaviors, positive youth development, and family functioning. Again, we are grateful for our funding for this research from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Mental Health, and the Center for Substance Abuse Prevention.

B. More detailed answer: As noted, over the past 15 years we have amassed substantial positive findings from a number of studies, in pursuit of our mission to promote healthy youth and families through school-community-university partnerships. The school-based and family-focused EBIs implemented have primarily focused on reduction of substance- and conduct-related problems. Benefits of EBI implementation extend beyond that, however, including positive effects on other mental health outcomes and mental health promotion (for example, enhanced parenting skills).

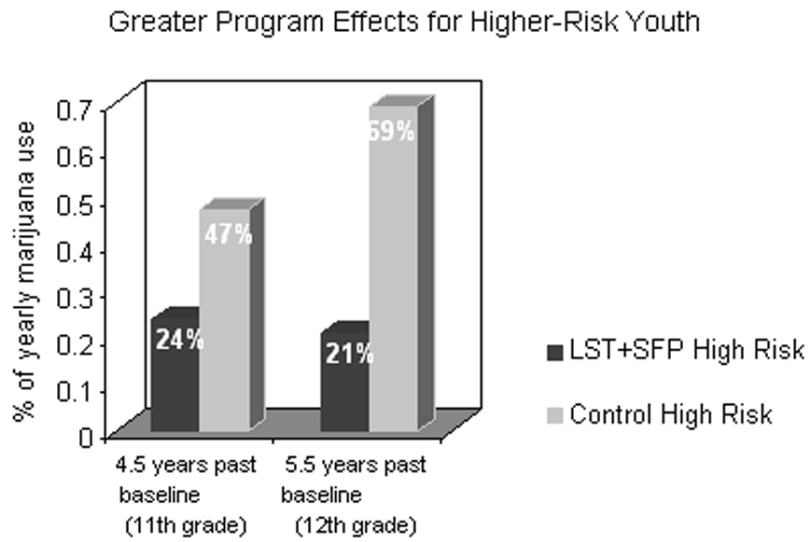
To illustrate positive longitudinal outcomes, in addition to those concerning methamphetamine use, in one of our studies we examined rates of substance initiation from 6th grade through 12th grade. The pattern of growth in initiation of substances of choice (for example, alcohol) follows a specific type of pattern, with an initially slow growth rate that rapidly increases and then returns to a slower growth rate in the latter years of high school. The estimated growth curves demonstrated statistically significant differences in the rate of growth for substance use for our family-focused EBI and control groups (see Figure below illustrating lifetime drunkenness). Other alcohol-related initiation measures (such as lifetime alcohol use) showed similar growth patterns (Spoth, Redmond, Shin, & Azevedo, 2004).

Lifetime Drunkenness 6 Years Past Baseline

Other analyses have focused on the average age at which students in each experimental condition reach a certain rate of use on a range of lifetime use measures. Such analyses allow for a comparison between the family-focused EBI group and the control group on the age at which a certain percentage of students (often 50%) have progressed from "no use" to initiation (e.g., begin smoking cigarettes). For example, if we look at when 50% of the students report ever being drunk, this occurred more than two years later in the EBI group than the control group (at age 17.8 vs. 15.5) (Spoth et al., 2004).



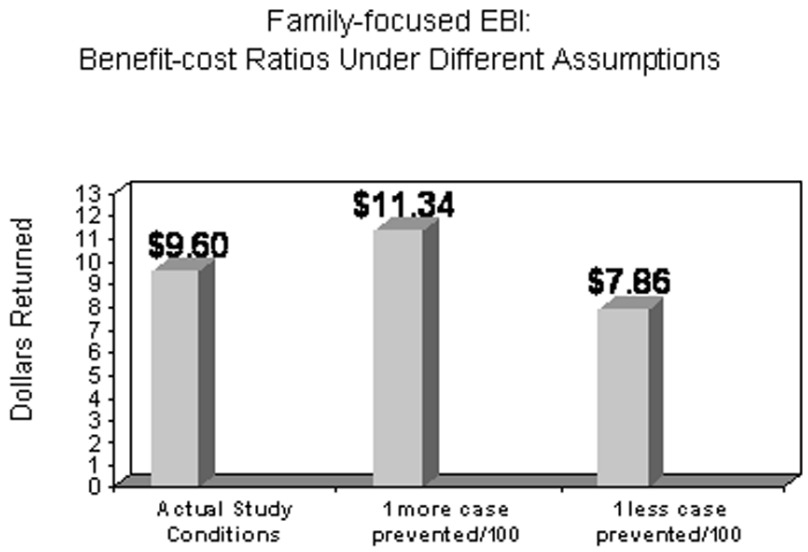
To determine whether EBIs are effective for high-risk students, effects on substance use for higher- versus lower-risk adolescents also are important to consider. Typically our interventions show that higher-risk youth and families benefit as much as lower-risk youth and families. In other cases, higher-risk youth benefit more. In the following example, youth are defined as higher risk if they already have used two or more substances—alcohol, cigarettes, marijuana—prior to implementation of the EBIs. The following graph illustrates strong intervention effects on yearly marijuana use for higher risk youth (Spoth, Guyll, & Day, 2002).



Note: ISFP is the Iowa Strengthening Families Program; SFP + LST is the Strengthening Families Program (revised ISFP) plus Life Skills Training.

Importantly, research at PPSI and that of others has demonstrated the economic benefits of these positive substance prevention outcomes. For example, to estimate benefit-cost ratios we used data on intervention effects on the delay of onset in alcohol use along with data on (a) the relation between delayed onset of alcohol use in adolescence and alcohol use disorders in adulthood, and (b) the societal costs avoided by preventing adult alcohol use disorders. The next figure shows the estimated return for each dollar invested in the family-focused EBI under actual study conditions—an estimated return of $9.60 for each dollar invested. If additional positive outcomes, such as those on meth use, were factored into the equation, the return would be even greater. The next figure also shows the expected changes in the dol-

lars returned when the number of adult alcohol use disorders prevented per 100 participants is increased and decreased by 1. The fact that the estimates remain well above zero suggests the robustness of the conclusion that the preventive intervention constituted a fiscally sound investment (Spoth, Guyll, & Day, 2002).



Also, the principal conclusion of an exhaustive analysis conducted by the Washington State Institute for Public Policy found that some EBI youth programs are excellent investments. This report suggests that whether funds are federal, state, or local government, corporate or private, investing resources in proven, "blue chip" prevention stock is fiscally sound. The Washington State Institute for Public Policy (Aos, Phipps, Barnoski, & Lieb, 2001) estimated the comparative costs and taxpayer benefits for over 60 prevention programs. PPSI's PROSPER project has successfully implemented several of the programs reviewed in this report. Each program shows a net savings per child attending and a positive return on investment (see table below).

	Project ALERT	All Stars	Life Skills Training	Strengthening Families Program: For Parents and Youth 10–14
SAVINGS per child attending	$54	$120	$717	$5,805
RETURN on every $1 invested	$18.02	$3.43	$25.61	$7.82

Information on other outcomes, including those on youth skills, parenting skills, family functioning, and mental health outcomes can be found on our website (ppsi.iastate.edu).

IV. How can our approach help to address the challenges of larger-scale prevention impact?

A. Short answer: Achieving larger-scale impact requires confrontation with some major challenges; infrastructure support and resources to expand the partnership network are needed.

B. More detailed answer: Two of the major challenges to achieving community-level impact of preventive interventions on a large scale concern EBIs. First, we need to increase the number of EBIs to serve youth and their families in a culturally-competent way, across all settings and all stages of youth development. Second, and most importantly, we need effective delivery systems that sustain large-scale, quality implementation of these EBIs.

As concerns the first need, over the past two decades the field of prevention science has been successful in greatly expanding the number of EBIs. Nonetheless, although many reviews of EBIs have catalogued a large number of relevant interventions for youth, families and communities (e.g., Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Durlak & Wells, 1997; Eccles & Gootman, 2002;

Gottfredson & Gottfredson, 2002; Greenberg, Domitrovich, & Bumbarger, 2000), most interventions implemented in real-world settings are not evidence-based. Further, more EBIs are required to meet the demands of all youth and families across rural, suburban, and urban settings.

Although noteworthy progress has been made in the development and testing of EBIs, limited headway has been made with the second challenge of sustained, large-scale, quality delivery of EBIs. The EBIs that exist are not widely disseminated, and those that are disseminated are often not implemented with quality, nor sustained over time (Ennett et al., 2003; Hallfors et al., 2002). Community partnerships are increasingly seen as a means of addressing this issue; however, we clearly need more research on the process of disseminating EBIs and scaling them up for greater public health impact. We also need capacity-building for sustained quality implementation both within and across networks of communities (Spoth & Greenberg, 2005).

Addressing the challenge of effective, large-scale delivery will require some difficult systems-level changes in our primary EBI delivery system. As an example, some needed changes were highlighted in a survey of Extension staff. Survey results suggested five key areas in need of attention: (1) changing countervailing organizational values or beliefs, such as the belief that existing resources should primarily sustain traditional programming (e.g., traditional 4H youth programs); (2) competing reward structures for Extension staff, such as rewards for reporting high numbers of people attending meetings or those reached through newsletters, rather than for EBI results; (3) competing programmatic resource demands for already-existing programs, plus the need to see new sources of funding for existing programs, (i.e., as described by Extension staff: "I'm always dealing with what makes the phone ring and the door swing"); (4) increasing administrative support for collaboration on EBI implementation; and (5) increasing the number of champions for EBIs. It is expected that following the model diffusion process described subsequently would greatly facilitate these types of changes, over time.

Our partnership model is designed for dissemination to states across the entire U.S. Indeed, a large number of states already have expressed interest in adopting our partnership model. Scaling up for widespread dissemination requires:

- A set of state-focused replication plans to bring our partnership model to additional states, to address a range of youth development and problem-behavior areas where EBIs could help.
- The development of infrastructure to support a network for new partnerships, including informational materials, technical assistance, and a structure for partnership networking.

We believe that it will be important to follow a diffusion of innovation approach (Rogers, 1995), starting with "early adopter" states that demonstrate readiness for successful model implementation, as capacity is built for supporting additional states and communities that subsequently adopt the partnership model. As the early adopter states show positive results from their pilot projects, the level of interest in adopting the model, and in developing the capacity to respond to that interest, would allow the partnership model to spread and the partnership network to develop.

In other words, a sequence would unfold in which, first, the model will be expanded to additional communities beyond the pilot communities within the early adopter states. Then, the dissemination model will be expanded into additional states, involving gradually increasing numbers of communities beyond the pilot communities. In addition, the model will be applied to positive youth development and reduction of problem behaviors beyond substance abuse and conduct problem prevention. For example, we are working with obesity prevention researchers to adapt the model to that area. The partnership model is a general framework that is not restricted to substance prevention interventions—although, to date, the evidence for model effectiveness has been focused on substance abuse and conduct problem prevention.

1. State-focused replication and expansion plans.

To start, replication efforts in additional states will focus on implementing and testing EBIs preventing substance abuse and conduct problems, along with related positive youth development for middle school youth. In all cases, replication projects will build upon existing partnership-related efforts within the state (such as Community Anti–Drug Coalitions of America, Communities that Care Coalitions). To ensure success of the replication effort we will consider the readiness of states and communities to implement the partnership model. This will include readiness assessments that evaluate interest in the project among opinion leaders within Extension and public education, as well as possibilities of partnering with prevention scientists and evaluators in the state. In addition, prospective communities that might

be involved would need to demonstrate commitment to prevention, the resources available for the community effort, and evidence of relevant past collaboration.

Each statewide replication effort will begin with the formation of a steering committee, with representation from Extension, prevention research scientists, the state Department of Education, and other stakeholders or potential funders. The steering committee will review interest in replication at the state and community levels; subsequently, the committee will make a decision concerning the level of interest and the presence of funding to drive a replication effort under their guidance, with support from the national partnership network infrastructure.

If the decision is made to proceed in prospective replication states, plans will be made for state team development, supportive infrastructure, and community pilot studies (ideally, three or four communities in each state). State leadership will be provided by the steering committee and a prevention coordinator, along with local leadership supervising a community team. Each community pilot will include funding for an evaluation component to inform project improvements as it proceeds and to contribute to a knowledge-base about the partnership model.

2. Partnerships Infrastructure Development and Research.

Necessary national infrastructure to support the network of partnerships will include:

a. an information dissemination component including a website;
b. technical assistance for each replication state;
c. partnership manuals and handbooks;
d. an information management system; and
e. a national-level steering committee, including representatives from both the replication states and the initiating states.

The partnership model in each replication state will be patterned after the existing PROSPER model currently being implemented in Iowa and Pennsylvania.

There are limited financial resources and capacity for partnership model diffusion and network development. With the probable reduction to the U.S. DOE Safe and Drug Free Schools funding, the pool of resources for substance prevention programming by community partnerships will be diminished. Given the increasing emphasis placed on demonstrating program effectiveness, it is worth restating that, based on 15 years of PPSI research, a high return on investment for substance abuse prevention would likely result when community partnerships implement EBIs with high quality, in conjunction with university partners that have the capacity to provide ongoing technical assistance and program evaluation.

From the perspective of the above described approach, the most effective use of federal dollars for substance abuse prevention requires: (1) effective linkages among key intervention delivery and evaluation systems; (2) strategic school-community-university partnerships; (3) the use of EBIs; (4) implementation with fidelity; and (5) sustainability planning. As an example of legislation that supports this type of approach, the HeLP America Act (HAA) is designed to have a positive impact on public mental health and well-being. To accomplish this goal, the HAA emphasizes the aforementioned key elements, including the highest caliber of programs, delivered with high quality by community-based partnerships. The HAA also recommends that strong emphases be placed on both sustaining the program after initial funding ends and on the importance of a high-quality programmatic evaluation to accomplish this goal. In other words, the HAA is one step in the direction of what clearly is needed in a steady and substantial long-term stream of funding.

In short, we believe an investment in the type of partnership approach outlined above would: (a) save money; (b) reduce substance use-related problems; and (c) improve youth and family health and well-being, making a "real world" difference.

Again, I thank you for this opportunity and I would be happy to answer any questions you may have.

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Mr. OSBORNE. Okay. Thank you.

I think we have a vote coming up, so, Ms. Cain, we will be able to take your testimony. Since a couple of people have to catch airplanes, we probably will not come back.

So we really appreciate it. I wish we had more time to ask questions, but why don't you go ahead with your testimony, Ms. Cain, at this point?

STATEMENT OF MS. CRISTI CAIN, STATE COORDINATOR, KANSAS METHAMPHETAMINE PREVENTION PROJECT, TOPEKA, KS

Ms. CAIN. Chairman Osborne and other distinguished members of the committee, thank you for the opportunity to testify today on behalf of the Kansas Methamphetamine Prevention Project. I am pleased to be able to provide information today about prevention efforts in Kansas and across the United States.

Methamphetamine production and use results in tremendous economic and social costs to communities across the nation, which includes property crimes and health care costs.

One major concern is for the children affected by their parents' methamphetamine use and manufacture, including children prenatally exposed. The cost of one meth-exposed infant can total over $1.7 million during their life span.

The statewide Kansas Methamphetamine Prevention Project was implemented in October 2002. KMPP provides training and technical assistance on comprehensive, community-wide strategies for addressing the methamphetamine problem that focus on both reducing the supply of and the demand for meth.

Two-thirds of Kansas counties have implemented efforts to address methamphetamine, and we have assisted 38 states by providing training, technical assistance and resources.

Key components of what was implemented in communities across the state include training key community leaders, assessing the level of the meth problem at the community level, building public awareness by targeting specific community sectors with education, including retailers, farmers, property owners, hotel employees, first responders, and chance encounter occupations, including home visitation professionals, and through media campaigns.

Another key component focuses on changing specific features of the environment through efforts including Meth Watch, which is a program designed to engage retail stores, to address the sale and theft of meth precursor products, and also anhydrous ammonia control strategies.

Providing targeted education and skills building are also key components. We partner with Safe and Drug-Free Schools pro-

grams to ensure that effective drug prevention curricula and programming are implemented in the schools.

Our efforts include youth involvement and training for school staff. Working to change policies and practices at both the state and local level is another key component.

Kansas passed a Schedule 5 law which significantly reduces access to cold medications containing pseudoephedrine. Another law passed was an increase in the penalty for meth-related activity in the presence of a child.

Other changes in policies and practices have included policy changes in how community agencies provide services for children born meth exposed or found in meth environments.

Other strategies implemented include the development of drug-endangered children programs which have momentum nationally. Kansas has state and local efforts to assist children who have been affected by their parents' meth use and manufacture.

Counties implementing efforts reported decreases in thefts of precursor products, reduced usage by youth, reductions in perceived availability by youth, improved collaboration and increased public awareness.

A case study evaluation completed in July 2004 demonstrates positive results in counties that fully implemented four key components. What they found was that three of the four fully implementing counties saw an all-time low in the perceived availability of meth among high school seniors, which were counter to both state-wide trends and trends of comparison counties.

All counties with available data saw improvement in reported rates of friends who used meth in the past year, and use of meth among high school seniors in the past 30 days decreased by as much as 24 percent from levels reported before project implementation.

In the course of doing this work in Kansas and throughout the nation, we have gained significant knowledge. I wanted to share some key lessons for effective meth prevention.

One is that meth is a multidimensional problem that demands comprehensive, coordinated solutions involving the collaboration of multiple community sectors. It cannot be solved by law enforcement alone, which is a common belief in many communities.

Second, the need to build and sustain effective prevention infrastructures and communities must be instilled as a national, state and community value. As funding priorities shift and drug trends change, effective prevention efforts are often cut or eliminated.

A coordinated effort to provide expert technical assistance, resources and training for communities is essential. The Safe and Drug-Free Schools and Communities program is the foundation on which other school-based prevention efforts are built, and it is critical.

Effective meth prevention must be data-driven. And we have found that small amounts of startup funding can engage communities in comprehensive efforts to combat meth that leverage other community resources.

I wanted to close with a success story from Rice County, Kansas which is very rural and has a population of about 10,000 people. They implemented comprehensive efforts in early 2003 as a result

of access to training, resources including mini-grant funding, and ongoing support from our project.

Outcomes in the county show significant reductions in perceived availability of meth, friends who use meth and lifetime use. It is clear that prevention efforts can make a significant difference for communities working to address this meth problem.

Thank you for the opportunity to testify about our experiences gained from working in Kansas and other states throughout the nation.

[The prepared statement of Ms. Cain follows:]

Statement of Cristi Cain, State Coordinator, Kansas Methamphetamine Prevention Project, Topeka, KS

Chairman Castle, Ranking Member Woolsey and other distinguished members of the Subcommittee on Education Reform, thank you for the opportunity to testify before you today on behalf of the Kansas Methamphetamine Prevention Project. I am pleased to be able to provide information today about prevention efforts to address the methamphetamine problem in Kansas and across the United States.

The Impact of Meth:

Methamphetamine production and use result in tremendous economic and social costs to communities across the nation including: law enforcement and incarceration; clean-up of clandestine lab sites; addiction treatment; domestic violence; theft, burglaries, and other property crimes; emergency medical treatment; HIV/AIDS; workplace violence; environmental contamination; murders and suicides. The Kansas Bureau of Investigation estimates the percentage of property crimes which are meth-related at approximately 50% for many Kansas communities. Meth-related health care costs have also increased significantly. It is estimated that the damage to the teeth of one meth user costs approximately $7,000 to repair (Lonna Jones, Supervisor, Sioux River Valley Community Dental Clinic, 2005). Other associated health care costs include treatment of overdoses, burns, and infectious diseases such as hepatitis B and C which are very common among injecting meth users. As meth users are jailed and incarcerated, many local and state governments must absorb these tremendous costs.

Methamphetamine manufacture and use also lead to child abuse and neglect including exposure to environmental hazards, sexual abuse and other health issues (Dr. Wendy Wright, San Diego Drug Endangered Children Team, 2002). Children exposed to methamphetamine environments are at great risk for physical, emotional, and developmental harm. These children frequently suffer from respiratory conditions, are malnourished and experience developmental delays. Based on information from several Kansas hospitals, it is apparent many communities have a significant number of children born exposed to meth due to their mothers" use of the drug during pregnancy. These children are six times more likely to have birth defects, and 30% more likely to be born pre-term, and experience neurological conditions. As they grow older, these children are highly likely to be diagnosed as ADHD and have impulse and anger control problems (Dr. Rizwan Shah, Blank Children's Hospital, Des Moines, Iowa). The cost of one meth-exposed infant over his or her lifespan can total over $1.7 million dollars. This estimate includes the costs to school systems for special education and other services for these children estimated at approximately $75,000 per child. (Dr. Dennis Embry, Paxis Institute).

The Kansas Methamphetamine Prevention Project:

Efforts to address methamphetamine began in 1999 in Shawnee County, Kansas (pop. 169,871) as a pilot project. Using the Shawnee County project as a model, the Kansas Methamphetamine Prevention Project (KMPP) was implemented in October 2002 in response to the devastating consequences Kansas communities were experiencing from methamphetamine production and usage. KMPP provides training and technical assistance on comprehensive, community-wide strategies for addressing the methamphetamine problem that focus on both reducing the supply of and demand for meth. When efforts began in 2002, four statewide trainings of trainers were conducted. The purpose of the trainings was to demonstrate the need for communities to address the problem, provide key background information needed for community awareness, and provide resources needed for communities to quickly implement proven strategies. Additionally, participating communities were eligible to apply for minigrants which served as start-up funding for the implementation of

methamphetamine prevention efforts. One key aspect of KMPP's success is that it teaches communities to be data driven in dealing with the meth issue. KMPP trains communities to collect and analyze baseline data to assess the level of their specific meth problem. Participating communities collect and analyze data from various sources such as: student surveys, law enforcement, prisons and jails, retail stores, treatment and other social service providers. Once they have a clear picture of the extent and consequences of the meth issues in their community, KMPP helps them implement a comprehensive array of evidence-based strategies and programs to address the meth issue, across the entire spectrum of community institutions and citizens that actually meet their community's specific needs. KMPP also teaches communities to use an online evaluation and documentation system to track their outcomes over time.

To date, 66% of Kansas counties have implemented efforts to address methamphetamine through the assistance of KMPP. Additionally, KMPP has assisted 38 states by providing training, technical assistance and resources. KMPP has also assisted with the implementation of a national model for engaging retail stores, Meth Watch.

KMPP has found that the success of meth prevention efforts is dependent upon the extent to which schools, law enforcement, parents, businesses and other community systems and groups work comprehensively and collaboratively to implement a full array of education, prevention, enforcement and treatment initiatives. KMPP has modeled this comprehensive approach itself, by partnering in the development and implementation of its entire program with a wide variety of interdisciplinary partners including: Kansas Bureau of Investigation; Kansas Department of Health and Environment; Midwest HIDTA; Kansas Regional Prevention Centers; K–State Research and Extension; Kansas Social and Rehabilitation Services; Addiction & Prevention Services & Children and Family Policy Division; Kansas National Guard; Shawnee Regional Prevention and Recovery Services; Kansas Family Partnership/ RADAR Network; Kansas Farm Bureau; Sedgwick County District Attorney's Office; United States Attorney's Office–Wichita; Community Systems Group; and the University of Kansas.

The specific array of strategies and programs that have been developed for communities to implement through KMPP are organized into the following four core component groups: (1) build public awareness; (2) provide targeted education and skills building; (3) change specific features of the environment; and (4) seek relevant changes in policies and practices of key local institutions.

Build Public Awareness:

Community Awareness: Focus on educating multiple community sectors about how to identify and report methamphetamine activity and how to address the meth problem in a community. Awareness activities include town hall meetings, trainings, community-specific educational materials, and implementation of Neighborhood Watch. Sectors targeted include parents, property owners, hotel/motel employees, neighborhood residents, chance encounter occupations including realtors, gas service employees, and hunters, judges, prosecutors, day care providers, child protective service workers, and health care professionals.

Media: Efforts include public service announcements for television and newspapers, news conferences, billboards, and press releases with subsequent coverage of events. The Project has a website which provides access to information about strategies and resources. Additionally, a quarterly E-newsletter is distributed to individuals in communities across the state with updated information about resources available, legislation, training opportunities, and current trends.

First Responder Training: Provides emergency personnel current information for recognition of methamphetamine activity and appropriate responses.

Safety Training for Home Visitation Professionals: Training was designed for social workers and other professionals who enter homes where meth activity may take place after it was discovered that these employees, who are mostly female and enter homes alone, have limited safety training. The training focuses on recognition of meth activity and safety information.

Web-based Training: Two trainings accessible via the Internet have been created. One is geared toward social service professionals and one provides general information about methamphetamine.

Change Specific Features of the Environment:

Meth Watch: Created in Kansas in 2000, Meth Watch utilizes signage to deter theft and purchase of precursor products in retail stores, includes an employee training program, educates customers, and encourages reporting of suspicious trans-

actions to law enforcement. Outcomes include reduced thefts of precursor products and increased arrests based on intelligence from retail personnel.

Rural Strategies: Focus on educating farmers and ranchers about preventing theft of anhydrous ammonia by making tanks less accessible and utilizing surveillance equipment. One strategy to inform farmers their tanks had been tampered with were 18 inch stainless steel tamper tags. 75,000 tamper tags have been distributed across Kansas. Additionally, Shawnee County implemented a pilot project placing a locking device on every anhydrous ammonia tank in the county. An evaluation will be completed to determine the effectiveness of the project. Evaluation results from other states have demonstrated reductions in the anhydrous ammonia method of manufacturing in communities with locks.

Provide Targeted Education and Skills Building:

School and Youth Involvement: Partner with Safe and Drug Free Schools programs to insure that effective drug prevention curricula and programming are implemented in the schools; usage of meth-specific curriculum created by Midwest High Intensity Drug Trafficking Area; presentations to youth in schools; in-service trainings for teachers and other school staff; special events in schools; involving existing youth organizations (e.g. SADD, 4–H, Future Farmers of America)

Relevant Changes in Policies and Practices in Key Institutions:

Legislation: Kansas passed a Schedule V law which went into effect June 1, 2005. All cold medications with ephedrine or pseudoephedrine as the active ingredient in starch form are available at pharmacies only. Sales are limited to 3 packages in a 7 day period. Customers must show identification and sign a pharmacy log. The law was passed in response to an increase in activity after Oklahoma passed a similar law in 2004. Early indicators suggest a significant reduction in methamphetamine lab seizures as a result. Another law passed was an increase in the penalty for meth-related activity in the presence of a child from a misdemeanor to a felony.

Other changes in policies and practices have included utilization of reporting forms by law enforcement agencies, gaining cooperation from retail stores in implementation of components of Meth Watch, policy changes in how community agencies provide services for children found in methamphetamine environments, and implementation of screening systems to identify use of substances by pregnant women.

Other Strategies:

Drug Endangered Children (DEC) Programs: Kansas has state level efforts and local efforts to assist children who have been affected by their parents" meth use and manufacture. The Kansas Alliance for Drug Endangered Children provides oversight, training and technical assistance to communities implementing DEC programs. Thirty-one Kansas counties have DEC programs. One county, Shawnee, has implemented a pilot project designed to address substance-exposed newborns.

Minigrants: Start-up funding awarded to communities for implementation of meth prevention and education efforts.

Resource materials: Include a community methamphetamine prevention kit that contains a 15 section manual with in-depth information about implementation of strategies; a CD-rom with presentations for multiple target audiences, videos, brochures, press releases, statistics, and multiple documents which can be updated with community specific information; and other materials; and quick reference cards for home visitors.

Outcomes in Kansas:

In July 2004, the Community Systems Group completed a case study evaluation of KMPP. KMPP showed positive results in the perceived supply of methamphetamine, demand for methamphetamine, and in the use of methamphetamine among high school seniors in the October 2002–September 2003 time period. These positive results occurred in counties that fully implemented the Project's four recommended components and are based on case studies of intervention and comparison counties. More than thirty-five counties in Kansas began implementing the four core components of the KMPP in 2003. Counties implementing efforts reported decreases in thefts of precursor products, reduced usage by youth, reductions in perceived availability by youth, improved collaboration, and increased public awareness.

Four counties were able to achieve "full implementation" in the first twelve months. A county is considered to be "fully implementing" when all four of the core components are put in place and have widespread/county-wide adoption. Given that the only specific financial resources provided to local communities for this comprehensive meth prevention program came in the form of minigrants (most were for less than $1,000), it is a testament to how important the meth problem is in these counties that key leaders stepped forward and provided the time, resources and assets of their local community to support project implementation. For the fully imple-

menting communities, the investment of substantial local resources appears to be paying off.

Key findings of the case studies include:

Three of the four fully implementing counties saw an all time low in the perceived availability of meth among high school seniors.

These improvements in perceived availability ran counter to both statewide trends and the trends of comparison counties.

All counties with available data saw improvement in reported rates of friends who used meth in the past year (to rates that were a historical low).

For counties with available data, use of meth among high school seniors in the past thirty days decreased by as much as 24% from levels reported before project implementation.

Ten Lessons for Effective Meth Prevention:

1. The meth problem will not be solved through law enforcement or any single sector alone. Meth is a multi-dimensional problem that demands comprehensive, coordinated solutions involving the collaboration of multiple community sectors including law enforcement and other first responders, health care professionals, social service providers, treatment providers, retailers, farmers and ranchers, youth, schools, parents, faith communities, court system representatives and media.

2. The need to build and sustain effective prevention infrastructures in communities must be instilled as a national, state and community value because as funding priorities shift and drug trends change, effective prevention efforts are often cut or eliminated. In Kansas, the utilization of a statewide prevention infrastructure which includes a Regional Prevention Center system that provides training and technical assistance to communities across the state, access to data from the statewide Communities that Care school survey, and utilization of an online evaluation and documentation system at the University of Kansas was a key to efficient local and state level implementation of meth prevention efforts.

3. The provision of expert technical assistance, resources and training for communities is essential. Success was related to a coordinated, reliable organization which could provide current information relevant to their community about the issue, data to demonstrate the need for efforts, and support for ongoing efforts.

4. The Safe and Drug Free Schools and Communities program is the foundation on which other school based prevention efforts are built. The program provides the only portal into schools for community anti-drug efforts. This program is a component of any comprehensive strategy to address meth issues in communities around the country.

5. Effective meth prevention must be data driven, from the initial collection of baseline data to determine the extent of the problem through program implementation and evaluation of outcomes over time.

6. Programs and policies can be implemented at the state level but community-level involvement and buy-in is essential for meth prevention to work and obtain measurable results.

7. Small amounts of start-up funding can engage communities in comprehensive efforts to combat meth that leverage other community resources and major levels of citizen involvement.

8. In communities with existing coalitions to address substance abuse, efforts were more quickly implemented and had more success.

9. To be optimally effective, communities need to pick the specific programs they implement, from the four core program components, to fit their local needs, based on local data and circumstances.

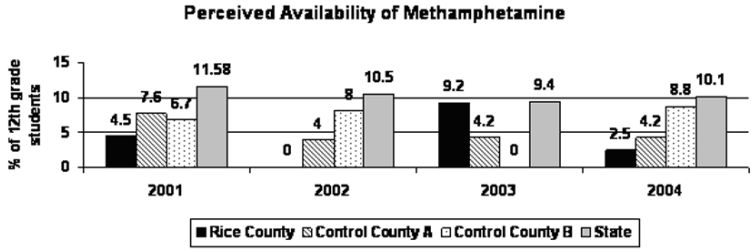
10. Establishing a model program in one community that could then be adapted and replicated across communities led to faster, efficient implementation.

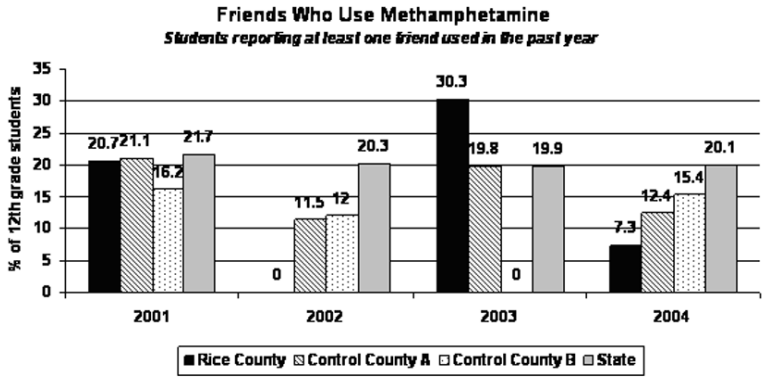
A Community Success Story:

Members of an existing coalition in Rice County (population 10,412 and a land area of more than 700 square miles) attended the KMPP training-of-trainers in November 2002. Because of access to training, resources including minigrant funding, and ongoing support from KMPP, the coalition was able to quickly implement key components. Before working with KMPP, county officials reported that no one had the time, money, or expertise to implement methamphetamine prevention efforts.

Rice County's efforts included county-wide implementation of Meth Watch, implementation of rural strategies including education and tamper tags, extensive media coverage, significant information dissemination which included meth prevention tips being distributed to 14,000 people in the region through partnerships with banks, prevention efforts in schools, and utilizing community events as a venue for reaching citizens to inform and involve.

Results from the Rice County youth survey appear strong. Perceived availability and reported rates of friends who use were both down significantly. The rate of lifetime usage of meth declined from an all-time high of 13.8% in 2003 to 5% in 2004, which was below the state average of 6.4%. High implementation paired with a comparatively smaller community may have resulted in a higher "dose" of the intervention for the community. Where comparison counties" rates of perceived availability either worsened or stayed the same, Rice County's results improved. Furthermore, only Rice County saw results that represented historical lows for all the outcomes.





It is clear that prevention efforts can make a significant difference for communities working to address the methamphetamine problem. Thank you for the opportunity to testify about our experiences gained from working in Kansas and other states throughout the nation.

Mr. OSBORNE. Thank you very much.

I would like to thank the panel. I apologize for the timing of these votes, but they never seem to come at a good time. And so we will probably go over and name a post office or do something really critical today.

But we do thank you for your written testimony. It will be very valuable. We will use this to elevate the issue before Members of Congress. Your being here, your presence, is important. And we want to thank you for coming very much.

So since there is no further business, the subcommittee stands adjourned. Thank you for being here.

[Whereupon, at 11:34 a.m., the subcommittee was adjourned.]

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