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United States Senate Caucus on International Narcotics Control
Dirksen Senate Office Building, Room 562
Washington, DC 20510

The Status of Meth: Oregon's Experience Making Pseudoephedrine Prescription Only

Tuesday, April 13, 2010, 10:00 am to 12:00 pm

Dear Co-Chairman Feinstein, Co-Chairman Grassley, and distinguished members of the Senate Caucus:

Thank you for the opportunity to speak with you about the important topic of domestic methamphetamine production and what I believe to be the only viable solution to this problem: Prescription pseudoephedrine.

My name is Kent Shaw and I come before you today with 23 years of law enforcement experience, 20 years of which has been devoted to drug enforcement. As a local police officer, task force agent, and special agent I have investigated hundreds of methamphetamine cases and seized more than 100 methamphetamine laboratories. While a task force agent and special agent I was assigned to a Clandestine Methamphetamine Laboratory Enforcement Team. I also directed investigations of significant drug trafficking organizations that involved the interstate and international trafficking of methamphetamine and other drugs. I received many hours of specialized training in the methods used to locate, identify, seize, and handle hazardous materials associated with methamphetamine labs. I have also testified as an expert witness in the manufacturing of methamphetamine in both federal and state courts. Additionally, in a training environment, I have actually manufactured methamphetamine. I later served as a drug unit supervisor, a commander of several multi-jurisdictional task forces, and a regional manager overseeing methamphetamine investigations.

My current position is the Assistant Chief of the California Department of Justice, Bureau of Narcotic Enforcement (BNE). Some of my responsibilities include the administration of California's Methamphetamine Strategy (CALMS), the California Clandestine Laboratory Enforcement Program (CLEP), the California Controlled Chemical and Substances Program, and California's Prescription Drug Monitoring Program. I am also an advisory board member for the National Methamphetamine and Pharmaceutical Initiative (NMCI), a component of the President's Office of National drug Control Policy (ONDCP). I also assist the National Drug

Intelligence Center (NDIC) with the formation of the National Drug Threat Assessment and I am an executive board member of the Northern California High Intensity Drug Trafficking Area (HIDTA). Finally, I have served on the California Governor's Prevention Advisory Committee for methamphetamine.

The Bureau of Narcotic Enforcement is statutorily mandated to provide training and assistance to state and local law enforcement and prosecutorial agencies in apprehending and persecuting persons involved in the unlawful manufacture of controlled substances. California has always been and still remains our nation's epicenter of domestic methamphetamine production. The U.S. Drug Enforcement Administration (DEA) estimated that 80% of our nation's methamphetamine comes from California. Although California no longer seizes the most meth labs in the country, it still produces the most meth by far. For example, the production capability of California's seized meth labs typically exceeds the production capability of the combined meth labs seized in the four top states.

Introduction

The domestic production of methamphetamine in the United States is increasing and the primary reason is the abundant supply of meth's essential precursor: Pseudoephedrine. Law enforcement across the United States seizing clandestine methamphetamine laboratories report that over-the-counter pseudoephedrine products are the sole source of the essential precursor being used to make meth. For the past 25 years the political battle to adequately address the manufacturing of methamphetamine has pitted the competing interests of commerce versus public safety. This struggle has occurred in other arenas in our country's young history, and the safety of our citizens has, as it should, eventually prevailed. In the interim, while profits trump public safety, how much destruction of human lives and our environment will we endure? There is a solution to this human misery in the form of returning pseudoephedrine to prescription status, as it was prior to 1976. The debate 34 years ago about making pseudoephedrine a non-prescription medication focused on "product" safety – the debate today is about "public" safety.

A brief history - Those who cannot remember the past are condemned to repeat it

Government has attempted to enact effective measures to combat meth labs in America, but strong opposition from the pharmaceutical industry has consistently resulted in loopholes for criminals that made those efforts temporary and ineffective. We are once again at the same crossroads, and we cannot allow profits to usurp effective policy and public safety.

As methamphetamine began to emerge as a problem in California in the late 1970's, its production and distribution was largely controlled by outlaw motorcycle gangs. Almost without exception, the meth was manufactured using Phenyl-2-Propanone (P2P). Strong regulations of P2P and its precursor phenylacetic acid¹ essentially eliminated this process of making meth. In response, meth manufacturers learned that ephedrine and pseudoephedrine could not only be used make meth, but the cooking process is simpler and produces meth twice as potent as P2P

¹ P2P is a Scheduled II chemical under the Control Substance Act

meth. Currently there are a variety of methods used to manufacture methamphetamine and an assortment of interchangeable chemicals. However, there is no substitute for pseudoephedrine. The switch to using ephedrine and later pseudoephedrine to make methamphetamine coincided with the Mexican Drug Trafficking Organizations (MDTO) entrance into the meth trade. By 1990, MDTO's had cornered the meth trade in California and were setting their sights on illicit drug markets throughout the United States. These DTO's produce the majority of the meth made in California.

As experience has shown, effectively controlling the essential precursors needed to make a synthetic drug will dramatically curtail a criminal's ability to produce and distribute that drug. Notable success stories include controlling methaqualone powder that is used to make quaaludes, a variety of chemicals that are used to make PCP and, as was previously mentioned, the P2P method of making meth. These are all remarkable successes. Efforts to regulate a pharmaceutical precursor have proven to be a far more daunting task than regulating chemicals. During the past 25 years, law enforcement has tried repeatedly to enact meaningful legislation to control ephedrine and pseudoephedrine, only to be turned back by the pharmaceutical industry in each instance. Meth traffickers have relentlessly exploited the loopholes left open by lawmakers, which have resulted in a perpetuation of the human and environmental misery caused by making meth. The battle pits an effective and proven regulation against the profits of the pharmaceutical industry thinly veiled as concern about consumers' access to cold medication. The pharmaceutical industry's strategy to fend off a prescription pseudoephedrine law is similar to that of law firms representing big businesses in product liability cases – use the company's huge financial resources to influence the process and delay a resolution for as long as possible.

Starting in the late 1980's law enforcement began trying to control access to ephedrine because it was increasingly being used to make meth. An agreement between the pharmaceutical industry and DEA was reached in 1989 to regulate ephedrine powder, but that agreement excluded ephedrine pills. As predicted, meth cooks began using ephedrine pills they obtained in large shipments from wholesale and retail distributors. In response, another agreement was reached in 1993 that required sellers of ephedrine pills to keep records of customers, to report suspicious sales, and to register with the DEA. Once again, the pharmaceutical industry successfully created another loophole by excluding pseudoephedrine from the regulations. Again, as predicted, the meth manufacturers shifted to pseudoephedrine.

In 1995, DEA discovered that Clifton Pharmaceutical, a Pennsylvania based pill maker, had moved 70 tons of ephedrine to meth traffickers in the early 1990's, which sent Clifton's owner to prison for five years. Records seized by DEA at Clifton corroborated what law enforcement had predicted would happen: Clifton switched to pseudoephedrine after the 1993 law, purchasing 110 tons of the unregulated pills over an 18 month period. In response, law enforcement introduced regulations that required manufacturers and wholesalers to keep records if they sold more than 400 pseudoephedrine pills in one sale – enough for a 100 day cold using the recommended dosage. The pharmaceutical industry demanded that law enforcement prove pseudoephedrine pills were being used to make meth. At the time, DEA was only able to

document pseudoephedrine pills were used in 22% of seized meth labs, but anyone objectively looking at the facts knew the problem was just beginning to explode. Another compromise excluded pseudoephedrine pills sold in blister packs because, at the time, meth cookers preferred bottles of pills. This created yet another critical loophole. Another compromise diluted DEA's ability to place sanctions on rogue companies – instead of a three strike policy, law enforcement had to show a company had a “reckless disregard” for where its products were going. Not surprising, this policy only resulted in warning letters and did little to stop rogue companies from selling pseudoephedrine products to meth traffickers. By the time the new law went into effect, pseudoephedrine pills were seized at 422 meth labs, compared to only 93 labs in the previous year. Legal imports of pseudoephedrine jumped 160 metric tons in 3 years, a 41% increase. Once again, quite predictably, DEA reported that blister packs were found in 47% of seized meth labs in 1999 and 2000.

For a while, Canada contributed to the problem because it didn't have any of the regulations that existed in the U.S. A great deal of Canadian pseudoephedrine products were discovered at meth labs, particularly in California. Between 1997 and 2001, Canadian legal imports of pseudoephedrine quadrupled to about 140 metric tons. Canada eventually enacted similar pseudoephedrine regulations in 2003. In 2006, Congress enacted the Combat Methamphetamine Epidemic Act (CMEA). The CMEA sought to regulate the amount of pseudoephedrine products a consumer could purchase in a day and in a 30 day time period. The CMEA was important and well intended legislation, but the pharmaceutical industry had its way once again, creating loopholes.

The Combat Methamphetamine Epidemic Act (CMEA)

The CMEA, just as previous regulations, made a dent in domestic meth production, but only temporarily. The CMEA made it more difficult for meth cookers to get pseudoephedrine from retail outlets and that resulted in the reduction of meth lab seizures nationwide between 2005 and 2007, before that trend began reversing. Meth cookers adapted to the new regulations and once again seized upon the vulnerable loopholes. The CMEA legally requires a retailer to do very little: 1) it placed pseudoephedrine products “behind the counter;” 2) it required retailers to create and maintain a logbook (written or electronic); 3) it required retailers to obtain identification and have the customer complete the logbook; 4) it limited the sale of only 3.6 grams of pseudoephedrine products total per day (per regulated retail seller); 5) it allowed law enforcement personnel access to the logbook upon request; and 6) it placed a 9 gram 30-day limit on the **purchaser** only.

The CMEA actually created a cottage industry known as pseudoephedrine smurfing. Smurfing is a term originally coined by law enforcement in financial investigations and refers to the practice of using multiple people to make money deposits (structuring) in order to avoid currency reporting requirements. In the meth trade it refers to an individual, or more often a group of individuals working in concert, who purchase the daily amount of pseudoephedrine from multiple stores, which results in a large accumulation of pills. The CMEA has fueled a “Smurfing Epidemic.” The CMEA is an inconvenience to smurfers, not a solution.

Electronic Tracking

The resilient meth traffickers soon began to exploit the CMEA regulations and law enforcement quickly looked for a solution. Two potential solutions emerged: One saw Oregon pursue legislation that required a prescription for pseudoephedrine products, and the other looked for ways to plug the leaks in the CMEA. Soon after the CMEA was enacted, law enforcement realized the logbooks were more of a hindrance than help. The logbooks were often handwritten, illegible and incomplete, the data was basically useless unless it was compiled electronically so it could be analyzed, and access was difficult because some businesses required coordination from its corporate headquarters. Early on law enforcement thought an electronic logbook requirement would be a viable solution; the premise being that the data could be collated into a single database and the information could be used as actionable intelligence for identifying and investigating smurfers and meth cookers. And if such a system was integrated or linked amongst all retailers, illegal purchases could be denied by the retailers. Unfortunately, our experience with using electronic tracking systems has dashed that hope.

Law enforcement now knows that electronic tracking databases are not a viable solution for two primary reasons. First, even if an electronic tracking system works as designed, it still isn't capable of eliminating smurfing. Groups of people are still capable of legally purchasing enough pseudoephedrine to fuel many of the smaller "addiction" labs that plague most of the country. Second, the electronic tracking systems are vulnerable and easily exploited by smurfers who can purchase amounts beyond the legal limits. The use of multiple identifications and retail employee collusion with smurfers is electronic tracking's emperor with no clothes. Consequently, electronic tracking systems are, at best, just another investigative tool for law enforcement to chase smurfers, and worse, it creates a false sense of security while actually doing little to curb meth production.

The California Experience

If there is one thing I have learned throughout my 23 years in law enforcement, what happens in California will eventually spread across America, and this is particularly true in the illicit drug world. As previously mentioned, California remains as the epicenter of methamphetamine production and trafficking in the United States. Although California no longer leads the nation in the number of meth labs seized annually, it does still lead in the amount of meth produced each year. This is because California continues to be the home of the Super Labs – those capable of producing 10 or more pounds of meth per manufacturing cycle. These Super Labs need immense amounts of pseudoephedrine pills to feed the operation, and over-the-counter pseudoephedrine pills is exactly what Mexican Drug Trafficking Organizations are using.

Super Labs continue to operate in California because the Government of Mexico has banned the importation and use of pseudoephedrine. Consequently, production of meth in Mexico has shifted to the old P2P method, which produces a less potent form of meth. The decreased quality of Mexican meth is another reason why domestic meth production is escalating

and will continue to do so. A recent report published by the National Drug Intelligence Center (NDIC) chronicles this trend.²

Smurfing has become such a big business that criminals have shifted from trafficking drugs to become pseudoephedrine pill brokers. Unlike other parts of the country where many smurfers use the pills they buy to make meth themselves, many of the large sophisticated smurfing rings in California buy the pills because they have substantial profit-earning potential on the black market. A \$6 dollar box of pseudoephedrine pills in California is typically worth \$30 on the black market. In Missouri, that same box of pills is worth \$50 and in some parts of Kentucky it's worth \$70. A typical smurfing cell in California will employ approximately 30 smurfers to purchase pills from at least 20 stores each day. Collectively, those 30 smurfers are able to amass enough pseudoephedrine in a single day to make 4 pounds of methamphetamine. One smurfer can purchase enough pills in one day to realize a profit ranging from \$500-\$750 for a single day's work. Many people, including the homeless, are lured into the smurfing business for less than \$100 a day, something to eat, or a bottle of liquor.

No one denies that smurfing is a legitimate concern, but much debate centers on how pervasive the smurfing problem is. The pharmaceutical industry wants everyone to believe that smurfers only represent a very small percentage of total pseudoephedrine sales, but they refuse to share that data, stating it is proprietary information. Law enforcement believes, and I think logic supports, that the smurfing problem is substantial. One example in California revealed the smurfing problem in the Los Angeles area accounted for approximately 90% of the pseudoephedrine sales. CVS uses an electronic tracking system called MethCheck that was developed by Appriss, a company headquartered in Kentucky. On October 29, 2008, CVS implemented a block sale³ feature to its electronic tracking system (MethCheck) in California. In the first hours of the new system, CVS blocked 168 illegal purchases in California. Over the next 20 days, CVS blocked an additional 9,400 purchases of pseudoephedrine. An examination of the pseudoephedrine sales data before and after the implementation of the block sale feature of 11 random CVS stores in the greater Los Angeles area (Long Beach, Rosemead, Alhambra, El Monte, Van Nuys) produced startling results. In the month prior to the block sale, those 11 stores collectively sold 19,426 grams of pseudoephedrine. In the ensuing month after the block sale, those stores only sold 2,364 grams. That was an 88% reduction preventing the sale of 16,985 grams of pseudoephedrine that would have been enough to make approximately 4 pounds of meth. During that same time period, CVS experienced a dramatic increase in pseudoephedrine sales in Las Vegas, where many of the customers presented California identifications.

² <http://www.justice.gov/ndic/pubs38/38661/38661p.pdf>

³ "Block sale" is a system by which a retail store has an integrated network of information that permits one outlet to know the pseudoephedrine (PSE) sales information for all other outlets. Consequently, if someone had purchased the maximum amount of PSE permitted in a day and/or month, that outlet would block the sale of PSE to that person.

Another dramatic example of how significant the pseudoephedrine smurfing problem has become, and why it demands a comprehensive federal solution, is demonstrated by a recent law enforcement investigation. The Campos Organization is a Mexican Drug Trafficking Organization centered in Arizona. After a long-term investigation involving Arizona and California law enforcement, key members of the Organization were arrested and indicted in January of 2010. The investigation showed that the Organization employed 150 smurfers on a daily basis in Arizona. The organization supplied four separate Super Labs operating in California's Central Valley with 20,000 to 35,000 pills for each lab each on a weekly basis. The investigators determined the Campos Organization was supply approximately 400,000 pills each month to four Super Labs in California. Compared to the top meth lab producing states, Arizona doesn't have a large meth lab problem – yet – but it obviously has a huge pseudoephedrine smurfing problem. There are plenty of other organizations just like the Campos Organization exploiting our abundant supply of pseudoephedrine pills.

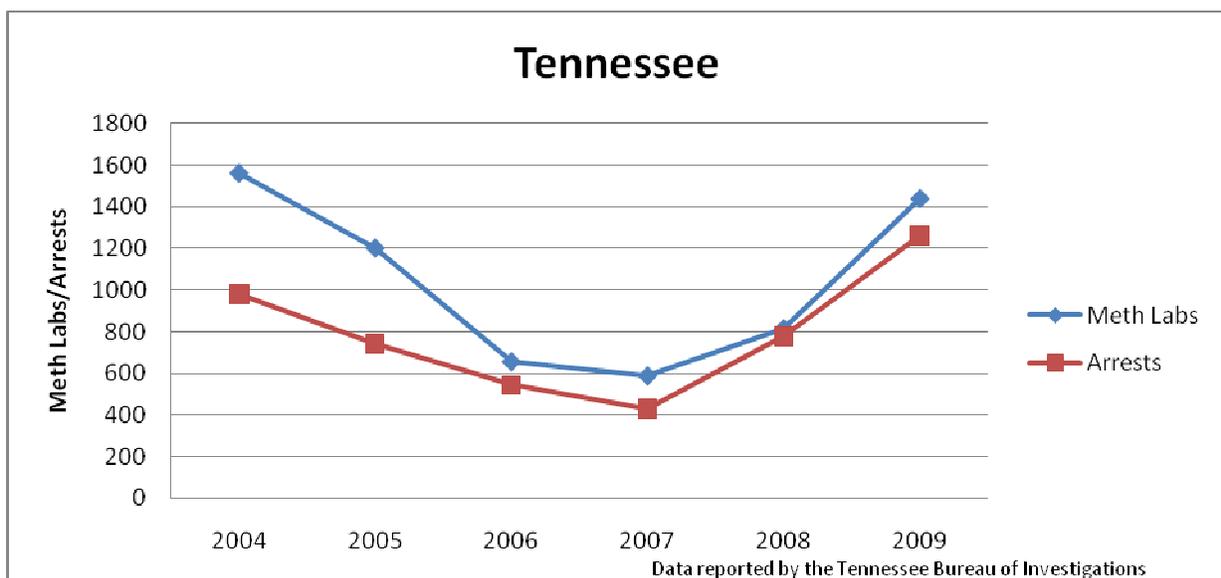
Based on my discussions with law enforcement throughout California and in other parts of the country, coupled with the results of investigations like the Campos Organization and others, I believe at least half of the pseudoephedrine being sold in retail outlets is being diverted to make meth. I presented this opinion to pharmaceutical executives (CHPA, Johnson & Johnson, Schering Plough) during a meeting in June of 2009, and the industry's response was, "We can't dispute that, we don't know how big the problem is - you guys are the experts." That means upward of half a billion dollars is being generated from pseudoephedrine sales that are feeding meth labs and not treating runny noses. Armed with the truth, what percentage of pills being used to make meth will society deem acceptable in support of profits and keeping a non-essential medication as an OTC?

Based on the previous example of the MethCheck's block sale feature, one could conclude that this was an effective deterrent to smurfers. In fact, it was, but only for a very short period of time. Smurfers adapted and began using fictitious or fraudulent identifications to circumvent the system. It is common for police to find smurfers in possession of multiple identifications, some possessing thirty or more. In addition to allowing the smurfers unfettered access to pseudoephedrine, the false identifications are corrupting the usefulness of the database. Police commonly refer to these smurfers as "Ghost Smurfers" because it is a waste of time trying to locate a fictitious person from a fictitious record. Conveniently, MethCheck's system has an "inquiry" feature from which a customer can query the system and determine the next available date to make a purchase. Smurfers use this system to aid them in determining the next available date a particular identification can be used to buy pills – a smurfer's utility. Despite MethCheck's block sale feature, the system inextricably continues documenting people who have purchased beyond the legal limits, what they refer to as "exceedances." Much of the exceedances are the apparent result of employees overriding the system. MethCheck produces a list of top exceedances that police examine for investigative leads. Unfortunately, on average, about 90% of those leads are associated with fictitious identifications and inaccurate addresses. Even if the information was accurate, the volume of leads greatly exceeds law enforcement's ability to investigate them.

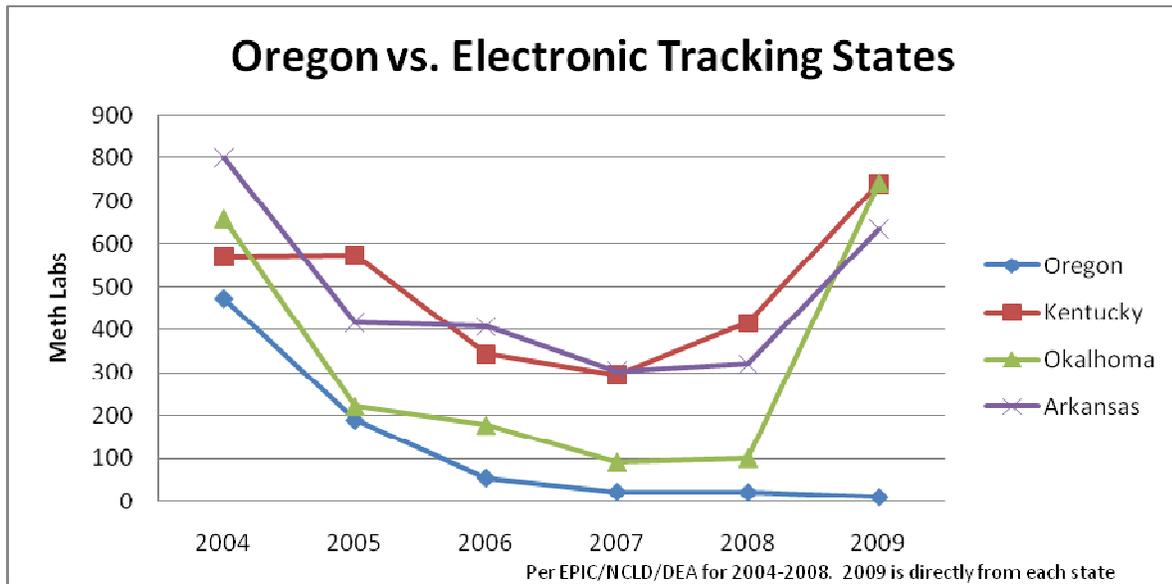
Smurfing investigations are very labor intensive. Teams of police are needed to follow the smurfers from store to store in order to collect the needed evidence for successful prosecution. Typically police need an entire week of investigating in order to arrest one group of smurfers. In California, smurfing investigations infrequently lead police to meth labs because the smurfers are often twice or more removed from the actual meth lab operators.

Another vulnerability of the electronic tracking systems involves retail employees' collusion with smurfers. MethCheck's electronic tracking system has an employee override feature that permits the employee to complete any sale. Police have arrested store employees who were smurfing pills. One case involved a CVS manager who would scan a product code and use multiple identifications to complete a virtual sale – he possessed 36 different identifications in this case. At the end of the day, the manager would put the amount of money corresponding to the amount of pseudoephedrine he scanned into the till and then he would carry the boxes of pills out the back door. On the day of his arrest, police discovered the manager purchased \$2,958 worth of pseudoephedrine pills that would have earned him approximately ten times that amount on the black market. Nothing in the electronic tracking system prevented this operation, nor would it have alerted police of its existence. The way law enforcement solved this significant diversion problem was good old fashioned police work: Surveillance.

Tennessee developed its own electronic tracking system and melded it into its intelligence database. Despite the system's attempt to prevent meth labs, Tennessee's meth labs seizures have steady climbed. In 2007, Tennessee seized 589 meth labs; in 2008, it seized 815 meth labs; and in 2009, in seized a staggering 1,437 meth labs. Tennessee has also dramatically increased the number of people it arrested each year for meth labs. In 2007, Tennessee arrested 428 people, but that number rocketed to 1,260 people by the end of 2009. Tennessee's experience clearly demonstrates that we will never arrest our way out of this problem. No state has implemented an electronic tracking system that has resulted in decreasing the amount of meth lab incidences.



The State of Kentucky first implemented a statewide electronic tracking system using the MethCheck product in June of 2008. Kentucky was a good test state to examine the effectiveness of an electronic tracking system. With a relatively small population and the fact that pseudoephedrine can only be sold in pharmacies, Kentucky offered great promise that an integrated system such as MethCheck with a block sale feature would eliminate Kentucky meth labs. By the end of 2008, Kentucky's meth lab seizures had increased by 41% compared to 2007. By late 2009, Kentucky eclipsed its previous recorded amount of seized meth labs which occurred in 2004 – this represented a 61% increase in meth lab seizures from the previous year. Clearly the system wasn't preventing smurfing, but it was helping law enforcement find some meth labs. The usefulness of the tracking system to find meth labs compared to its inability to prevent smurfing is an important distinction. Despite exaggerated claims to the contrary, according to a recent analysis by the Kentucky State Police, Louisville Police Departments, and four Kentucky narcotics task forces, the Kentucky MethCheck system now only leads to 10 percent of reported Kentucky meth lab incidents. As predicted, electronic tracking is simply being evaded by large numbers of smurfers. The evidence seems clear that the electronic tracking system is reactive at best, and is actually helping perpetuate the problem rather than solving it. This is why more than 15 public safety organizations in Kentucky, including the Kentucky Narcotic Officers' Association and the Kentucky Association Chiefs of Police, support legislation that will require a prescription for pseudoephedrine products. I believe all in law enforcement would agree, we don't want to find more meth labs, we want to prevent them.

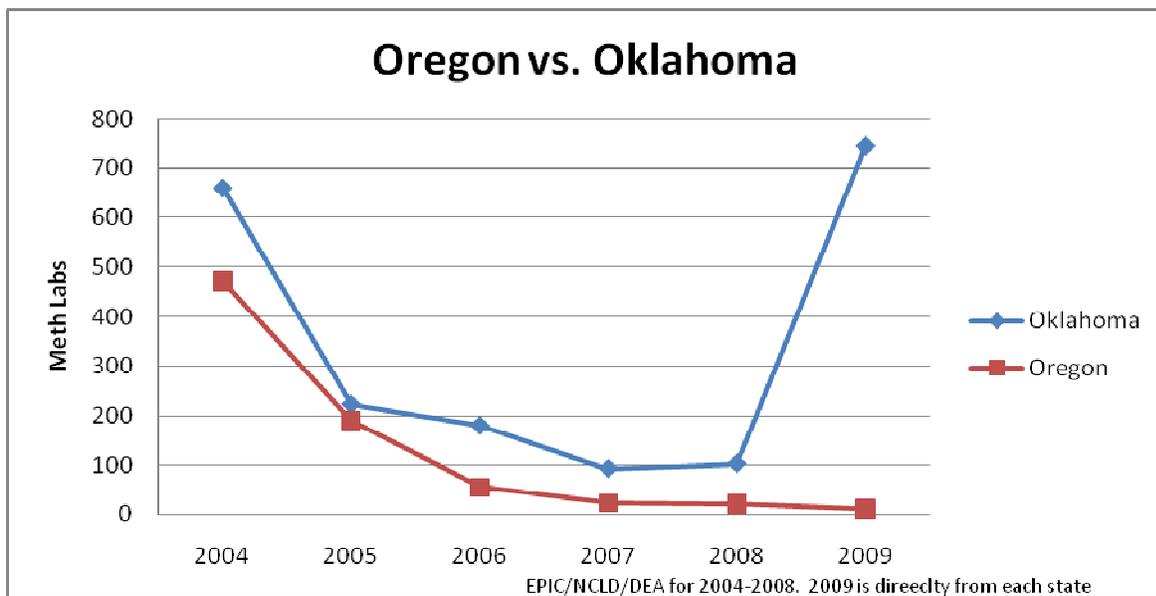


Prescription Pseudoephedrine – the Only Viable Solution

In my professional experience, based on twenty years of investigating meth labs, that the only way to effectively combat our meth lab problem is to require a prescription for pseudoephedrine. Unlike current efforts that are clearly not working, we have proof that requiring a prescription for pseudoephedrine will work to eliminate smurfing and prevent meth labs. Prescription pseudoephedrine is pure prevention, not a reactionary policy that necessitates

significant law enforcement resources. In 2005, the State of Oregon passed legislation returning pseudoephedrine to a prescription drug, as it was prior to 1976. The law went into effect on July 1, 2006, and the results have been an undisputable and resounding success. Oregon eliminated pseudoephedrine smurfing within its borders, it dramatically reduced the number of meth labs seized each year from a few hundred to 10 in 2009, and it has only removed one child from a meth lab in over three years, compared to 30 to 40 children that were commonly removed in years prior to the prescription law. Although Oregon’s law was intended to simply eliminate meth labs, it has produced other benefits. In addition to virtually wiping out meth labs, Oregon has also seen a dramatic decrease in meth arrests and our nation’s steepest decline in crime. Beyond the remarkable results Oregon has experienced, it is the fact Oregon has sustained those results that is most compelling.

In 2004, Oregon and Oklahoma took progressive steps to implement measures to attack the illegal availability of pseudoephedrine and their successes help spawn the CMEA (i.e., moved pseudoephedrine products behind the counter and required customers to show identification). However, in 2006, Oregon and Oklahoma pursued two different strategies: Oregon returned pseudoephedrine to prescription drug, and Oklahoma went with electronic tracking. A comparison of the two state’s results today clearly indicates that Oregon’s strategy was the correct choice. In sharp contrast to Oregon’s success, Oklahoma has recently experienced a sharp increase in meth lab incidents, and is approaching its own tragic record set earlier in the decade. This resurgence is fueled, of course, by smurfing.



Critics of Oregon’s success like to say that Oregon’s meth lab numbers were already declining prior to implementing its prescription law, so no real correlation can be made between the two. Such claims are baseless and ignore the facts. Oregon’s meth labs numbers were beginning to decline because it took progressive steps that would later become part of the CMEA. Just as other states’ meth lab numbers declined after the CMEA went into effect, Oregon’s numbers declined accordingly. However, there can be no doubt that Oregon’s numbers

would have reversed like the rest of the country had it not gone prescription-only. Since 2007, nationwide meth lab incidents have been increasing at an average rate of 17% per year,⁴ while Oregon's meth labs have decreased by 96% overall, and remain down.

In 2009, California introduced SB 484, attempting to replicate Oregon's law. The bill received broad support from all major law enforcement organizations and the California Board of Pharmacy. It is important to note that many pharmacy associations, as well as individual pharmacists, support requiring a prescription for pseudoephedrine. The pharmacists are continuously confronted by people they suspect are buying pseudoephedrine for illegal purposes and they do not want to police the problem. Despite SB 484 passing the Senate, the bill stalled in the Assembly Public Safety Committee by one vote. The bill was successful in educating many people about the issue, including the fact that it would save Californians millions of dollars each year.⁵ Not surprisingly, the greatest opposition came from the pharmaceutical industry. The industry made its usual arguments, but offered no evidence to support its contentions. Conversely, the supporters of SB 484 offered the proof that refuted the industry's "false parade of horrors."

One of the most disingenuous advertisements paid for by the Consumer Healthcare Product Association (CHPA) (the lobbying group that represents the pharmaceutical manufacturers) was an ad that appeared on CNN.com, and many other locations, stating that SB 484 sought to make "ALL allergy medicines prescription only." CHPA knows better than anyone else this is a lie because there are only about 15 product lines (and their generic equivalents) that still contain pseudoephedrine while there are more than 100 alternative over-the-counter cold and allergy medicines that cannot be used to make meth and will be unaffected by pseudoephedrine legislation. It is interesting that when the pharmaceutical industry introduced phenylephrine (PE) as an alternative cold and allergy medication for pseudoephedrine, the industry marketed PE as a very effective medication, and still does today. When Oregon enacted its prescription law, many consumers simply switched to readily available PE or other OTC products. However, in defense of the goose that is laying the golden eggs, the pharmaceutical industry likes to argue that PE products are not as effective for some people as pseudoephedrine products. One company, Sine-Off, used its reformulated product as an advertising opportunity. A Sine-Off television advertisement boasts:

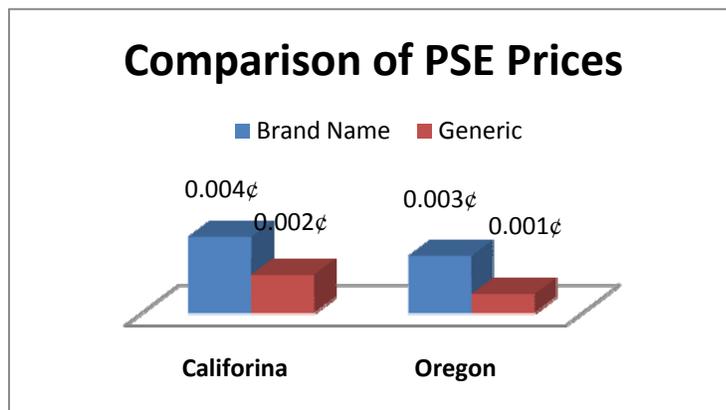
"Big news – Sine-Off cold, flu, and sinus congestion medicine has reformulated and is effective against fever, sore throat, congestion and sinus pressure. Sine-Off has completely removed pseudoephedrine, the key ingredient needed to make crystal meth. Side effects may include reduced crime rates, cleaner neighborhoods, fewer house fires, safer communities. Sine-Off, fight your cold, flu and sinus congestion while also fighting the effects of meth on our community."

⁴ According to EPIC, National seizures were: 2007=6,093, 2008=7,253, 2009=8,823

⁵ <http://www.oregondec.org/CASB484/SB484-Savings.pdf>

Another contention against prescription only is that it will increase healthcare costs. According to the Oregon Department of Human Services, its prescription law resulted in an annual increase of \$7,780 to the state’s Medicaid program.⁶ As the Interim Assistant Director stated, “The increase in the cost of prescription to the state’s Medicaid program is far outweighed by the decrease in costs associated with public safety, emergency room visits, and social services.” In California, Medical patients who want their insurance to pay for over-the-counter products must already obtain a prescription, so this is a non-issue. As for the insurance “co-pay” threat, this is another issue that doesn’t hold water. People already pay for pseudoephedrine products, so when it becomes a prescription-only medication, they can continue to pay just as they did before if they don’t want to use their insurance. And this leads to the next misleading contention – a prescription-only law will increase the cost of pseudoephedrine.

In 2009, the California Bureau of Narcotic Enforcement conducted an analysis comparing the cost of pseudoephedrine products, both brand name and generics, amongst retailers operating in both Oregon and California. The fact is that pseudoephedrine is less expensive in Oregon than it is California.⁷



Another red herring offered by the opponents of a prescription-only law is that the uninsured will be adversely impacted and will flood emergency rooms seeking pseudoephedrine. This predicted outcome simply didn’t happen in Oregon. The Oregon Chapter of American College of Emergency Physicians reported no examples of patients seeking pseudoephedrine in emergency rooms. They went on to say, “Given the clear relationship between the use of pseudoephedrine and the creation of methamphetamine, and plenty of viable alternatives on the market to use for decongestants, we think that this law in the state of Oregon has had a clear benefit without any compromise to the health of our citizens.”⁸ In addition, according to the Director of Northwest Human Services, which runs free clinics and homeless shelters in Salem, Oregon, the prescription only law “isn’t an issue” because there are so many alternative products.

⁶ <http://www.oregondec.org/CSPSC/012b-DHS.pdf>

⁷ <http://www.oregondec.org/CSPSC/013-Prices.pdf>

⁸ <http://www.oregondec.org/CSPSC/008a-ACEP.pdf>

Another issue opponents of prescription-only legislation like to claim is that pseudoephedrine is an essential medication. Pseudoephedrine is NOT an essential medication. Pseudoephedrine doesn't cure anything. It relieves the symptoms of a cold or allergy (nasal or sinus congestion). It does not, by any means, treat the underlying cause of the medical condition, nor will it speed up recovery. Essential medications are those that treat illnesses that, if left untreated, will result in serious harm or death. For example, an essential class of medication includes insulin, blood pressure medication, or medication to control heart function. These medications are truly essential, because if they are not taken, or another viable alternative is not available, this will likely result in serious health consequences and potential death. Recognizing this, the governments of Mexico and other Central and South American countries have banned pseudoephedrine altogether – clearly they have deemed pseudoephedrine as nonessential. In addition, the Czech Republic and New Zealand have implemented nationwide prescription pseudoephedrine policy. Doctor Alex Stalcup, a highly respected physician in the substance abuse treatment field said, “In sum, the risks of pseudoephedrine in a non-prescription OTC preparation are well documented, and substantial, where it is only somewhat effective for the intended use. However, the benefits of restricting the illicit use of pseudoephedrine in methamphetamine manufacture are substantial.”⁹

A final argument against prescription-only legislation asserts that prescription medication abuse in the United States is a significant problem and criminals who doctor shop and use fraudulent prescription to illegally obtain prescription medication will simply do the same to obtain pseudoephedrine. While I wholeheartedly agree prescription medication abuse is a significant problem in the U.S., I strongly disagree that pseudoephedrine will likely be diverted into the black market through doctor shopping. Another of my responsibilities as Assistant Chief of the California Bureau of Narcotic Enforcement is administration of California's prescription drug monitoring program. Based on my experience and the current evidence, pseudoephedrine will not be regularly diverted as a prescription medication. It is significant to note that Oregon hasn't experienced a single instance of a prescription pseudoephedrine product being illegally diverted in the nearly four years since Oregon's law went into effect. The reason is because those who seek prescription medications, particularly opioids, to either feed their addiction and/or sell, do so because it takes only a few pills to get high or make money. For example, a single 80 milligram oxycodone pill costs about \$80 on the street. Additionally, the typical diverted prescription medication doesn't require a manufacturing process to be ingested. Even the most prolific prescription pill shoppers do not amass the volume of pills that would be required to make pseudoephedrine diversion practical or profitable. There are more profitable and simpler medications for criminals to tempt the law. If a criminal were to try and obtain large amounts of prescription pseudoephedrine, a prescription drug monitoring program can easily flag those rare occurrences.

⁹ <http://www.oregondec.org/CSPSC/008b-Stalcup.pdf>

Based on Oregon's success, the State of Mississippi passed a law requiring a prescription for pseudoephedrine that will take effect July 1, 2010. I am confident Mississippi will enjoy similar success to that of Oregon and significantly reduce its large and growing number of meth lab incidents.

In the State of Missouri, 10 separate communities (9 cities and 1 county) have enacted local ordinances that require a prescription for pseudoephedrine products. The early results are very promising. The City of Washington was the first to enact such an ordinance in July of 2009 and thus far that city has experienced a 90% drop in the amount of pseudoephedrine sold and an 85% reduction in meth related crimes. At the same time there has not been a corresponding increase in the sale of alternative products. Other than some legitimate customers who might drive to a neighboring city to purchase pseudoephedrine, this is a reflection of the scope of the local smurfing problem and the effectiveness of prescription-only regulation.

Conclusion

Meth labs are big business. They are big business for criminals, the pharmaceutical industry, retailers, companies selling electronic tracking systems, and law enforcement. So one doesn't have to wonder why we have the means to address the problem, but not the political will to make it happen. The industry has mastered appearing as if it is attempting to solve the problem, but in reality it is merely perpetuating the problem in order to continue reaping the financial gains generated by meth labs. My organization, the Bureau of Narcotic Enforcement, like other law enforcement agencies receives critical funding to combat meth labs. Undeniably, by solving this problem that funding will vanish. However, eliminating meth labs will allow law enforcement to focus on meth as an interdiction problem rather than a homegrown problem. The blight that meth labs have wreaked upon our country is far more important than preserving a portion of an agency's budget. Requiring a prescription for pseudoephedrine is the right thing to do and the only viable solution to rid our nation of meth labs. We, and particularly our children, have endured this unnecessary human misery for too long.