Statement of Rob Bovett
District Attorney, Lincoln County, Oregon
Legal Counsel, Oregon Narcotics Enforcement Association

before the

Subcommittee on Health Care, District of Columbia, Census and the National Archives

of the

Committee on Oversight and Government Reform

of the

United States House of Representatives

RETURNING PSEUDOEPHEDRINE TO A PRESCRIPTION DRUG

to end the

RESURGENCE OF DOMESTIC METH LABS

Tuesday, July 24, 2012
Room 2247
Rayburn House Office Building
Washington, DC

Dear Chair Gowdy, Vice-Chair Gosar, Ranking Member Davis, and Subcommittee Members Burton, Clay, Desjarlais, McHenry, Mica, Murphy, Norton, and Walsh,

Thank you for providing me the opportunity to discuss the important public health and safety issue of domestic meth labs, and how they can be prevented.

Pseudoephedrine (PSE) is the key ingredient necessary to make the most powerful variety of methamphetamine that addicts seek.[1] PSE is the precursor used in virtually all current meth labs in the United States.

Ten critical points:

1. In 1976, the Food and Drug Administration let a genie out of the bottle by permitting PSE to be sold over-the-counter. Ever since, Congress and states have put **band-aids** on the problem of retail PSE diverted to make meth, providing temporary relief, at best.[2]

2. The Oregon legislature **returned PSE to a prescription drug**, effective July 1, 2006.[3]

3. In 2007, **Mexico** followed Oregon's lead, and then went one step further by **banning PSE entirely**. The effect has been weaker meth coming out of Mexico – and more pressure to cook more potent meth in the United States using diverted retail PSE.[4]

4. The diversion of retail PSE to make meth typically comes in three forms of what is commonly known as "**smurfing**:" (a) Exceedence smurfing; (b) group smurfing; and (c) false ID smurfing.

5. **Electronic monitoring** of PSE sales has the ability to stop or identify exceedence smurfing, where an individual goes from pharmacy to pharmacy using the same ID. However, electronic tracking does not have the ability to stop, and is completely **evaded by**:

   (a) **Group smurfing**, where no single individual exceeds the retail sales limit; and

   (b) **False ID smurfing**, where an individual uses multiple false ID's to smurf more than the legal limit.

---

[1] It is also possible, using the same simple "reduction" process, to make the powerful variety of methamphetamine from ephedrine, and similarly to make amphetamine from phenylpropanolamine. Those two drugs are similar to PSE in both chemical structure and effect as decongestants. However, both are no longer on the market, due to safety issues. *See* www.oregondec.org/IN/Tab15.pdf at page 1198, second paragraph, and accompanying footnotes.

[2] For a detailed examination of this tortured history, *see Meth Epidemic Solutions*, 82 North Dakota Law Review 1195 (2006), www.oregondec.org/IN/Tab15.pdf. *See also* "The Meth Epidemic," FRONTLINE, PBS, www.pbs.org/wgbh/pages/frontline/meth/.

[3] The Oregon legislation returning PSE to a prescription drug in Oregon was contained in Enrolled 2005 Oregon House Bill 2485: www.leg.state.or.us/05reg/measpdf/hb2400.dir/hb2485.en.pdf. The PSE provisions are in Sections 11 through 13a on pages 5 through 8 of that enacted legislation.

[4] Meth production in Mexico by Drug Trafficking Organizations (DTOs) has since switched to more technically complicated methods of manufacture that do not require PSE, and produce meth that is half as potent as meth produced with PSE. The DTOs also use methods to enhance the potency of the weaker meth, but do not achieve the potency of meth produced with PSE.

6. **Electronic tracking** helps to **facilitate group smurfing**, and a PSE black market, by ensuring that no individual smurfer exceeds the retail sales limit. Smurfing of PSE now fuels thousands of meth labs each year across the Midwest and South, and fuels the "super labs" in Central California run by large drug trafficking organizations.[5]

7. **Smurfing also fuels addiction** within a community, by enabling addicts to buy a box of PSE for $5 and exchange the PSE directly for drugs, or sell the PSE at a massive markup on the black market, and then buy drugs with the profits.

8. In contrast, **returning PSE to a prescription drug eliminates <u>all</u> forms of smurfing**. Oregon has eliminated smurfing and is no longer a part of the problem. Further, with over six years of actual experience, there has not been a single reported meth lab incident where diverted prescription PSE was used to make meth in Oregon. PSE doctor shopping has not occurred, because PSE is not susceptible to doctor shopping in the same way as pain medicine. The few remaining Oregon meth lab incidents are nearly all located in counties along the Oregon border, and fueled by retail PSE from out of state.

9. **Electronic tracking therefore further delays an effective solution to the diversion of retail PSE** – all at the expense of lives, families, public safety and, most tragically, drug endangered children.

10. Oregon simply put the genie back in the bottle by returning PSE to a prescription drug – a pure **prevention** solution to the problem.[6] More recently, Mississippi replicated this proven solution.[7]

The pharmaceutical industry, and their surrogates, would have you believe a parade of horribles will occur if we return PSE to a prescription drug. Don't believe it. It is a ***false*** parade of horribles, and we have years of experience and evidence to prove it.

There were few complaints, and no public outcry, after PSE was returned to a prescription drug in Oregon on July 1, 2006.

The industry often argues that returning PSE to a prescription drug will drive up Medicaid costs, flood doctor offices, emergency rooms, and pharmacies with people seeking PSE to treat colds and allergies, and have a disparate impact on the poor. None of that occurred in Oregon:

---

[5] For an introductory primer on "super labs" and "super smurfing" in the West, *see* the written testimony of Kent Shaw from the California Bureau of Narcotics Enforcement (BNE) before the Nevada Legislature last year: www.oregondec.org/NV/Testimony-KS.pdf.

[6] Since Oregon's prescription-only law took effect, meth lab incidents have dropped by 96 percent and meth-related arrests by 32 percent. www.politifact.com/oregon/statements/2011/apr/02/rob-bovett/oregon-district-attorney-says-meth-lab-seizures-an/**.** Oregon also experienced a 33 percent reduction in meth treatment admissions, and a 35 percent reduction in meth-related emergency room visits. www.oregondec.org/OregonFactSheet.pdf.

[7] *See* Statement of Marshall Fisher, Director of the Mississippi Bureau of Narcotics, submitted today.

- With respect to impact on Medicaid, the Oregon Department of Human Services, which administers the Medicaid program in Oregon, has indicated the total economic impact on Medicaid from returning PSE to a prescription drug is about $7,780 per year.[8]

- With respect to impact on the poor, a couple years after the Oregon law went into effect, I asked the staff of the Oregon Criminal Justice Commission to make inquiries (they served as staff to the Oregon Meth Task Force, which I Chaired at the time). They were able to make contact with the directors of key service providers, and confirmed there was no disparate impact. By way of example, the Director of Northwest Human Services, which runs free clinics and homeless shelters in Salem, Oregon, checked with his clinic and shelter managers. The response: "We haven't heard a peep from either the patients or the providers since the change to pseudoephedrine. There are so many good alternatives that it isn't an issue."

- With respect to flooding hospitals, doctor offices, and pharmacies, a letter from the Oregon Chapter of the American College of Emergency Physicians (OCEP) indicates there was virtually no impact whatsoever; OCEP strongly supports the Oregon legislation, as does the Oregon Medical Association (OMA).[9] The Oregon State Pharmacy Association (OSPA) also strongly supports the Oregon legislation and, in the spring of 2008, conducted a survey of their membership, confirming that Oregon pharmacists strongly prefer PSE as a prescription drug.[10]

There are now only 15 products, and their generic equivalents, that even contain PSE.[11] All of these products are already behind-the-counter. Most consumers simply purchase non-PSE over-the-counter products that line store shelves.[12]

The industry's surrogates also trot out flawed estimates of retail PSE diversion rates,[13] and flawed industry-funded studies that attempt to cast doubt on the efficacy of returning PSE to a prescription drug, but ignore key facts and data.[14]

In Kentucky, the home of the industry-touted PSE electronic tracking system that has failed to reduce meth lab incidents, the industry has spent a record-breaking amount of money to stop Kentucky law enforcement from getting legislation passed to return PSE to a prescription drug.[15]

---

[8] The letter can be viewed at: www.oregondec.org/CASB484/DHS.pdf.

[9] The letter from OCEP can be viewed at: www.oregondec.org/CASB484/ACEP.pdf. The letter from the OMA can be viewed at: www.oregondec.org/OMA.pdf.

[10] The letter from OSPA can be viewed at: www.oregondec.org/CSPSC/007-OSPA.pdf.

[11] *See* www.oregondec.org/15.pdf.

[12] *See also* Statement Supporting Prescription-Only Pseudoephedrine Legislation, Allergy and Asthma Network, Nancy Sander, President, and Stuart W. Stoloff, MD, Board Chairman, www.oregondec.org/AANMA-PositionPaper.pdf.

[13] *See, e.g.,* www.oregondec.org/PSE-DiversionEstimate-KentShaw.pdf.

[14] The most recent example is an industry-funded and flawed study by the Cascade Policy Institute. *See* www.oregondec.org/ReplyToCascade.pdf.

[15] *See* "Meth, money and lobbying: Guess who's biggest spender again," *Lexington Herald-Leader* (June 5, 2012), www.kentucky.com/2012/06/05/2212626/meth-money-and-lobbying-guess.html. *See also* kynarc.org.

As others have testified, there has been a significant recent resurgence of domestic meth lab incidents. Not coincidentally, PSE imports into the United States went up 43% from 2008 to 2010. Retail sales of PSE in the United States directly fuel the resurgence of domestic meth manufacturing.

Returning PSE to a prescription drug will end smurfing and drive down domestic meth lab incidents. Meth makers will not have the ability to simply switch to other precursor drugs. The other methods of making meth without PSE require chemicals that are difficult to obtain, use processes that require more complex organic chemistry, and produce less potent meth. These are beyond the ability of average "user" meth cooks.

It is also important to make clear that each meth lab, no matter how great or small, poses an unacceptable threat to public health and safety. Even the smallest "one pot" meth labs poison their environment, often catch fire or blow up, and leave human tragedy and significant property owner and public expense in their wake, including the costs of cleanup, remediation, public safety, and medical care at burn units, to name just a few.

Especially with regard to "one pot" and other small "user" meth labs, most tragic are the drug endangered children who are forced to live in these toxic environments.[16] This is unconscionable, and must end.

It is long past time that Congress enacted an effective remedy for this unacceptable situation. We don't need any more band-aids on this gaping wound. We need a real solution.

Thank you again for the opportunity to discuss this important national public health and safety issue. Please don't hesitate to contact me if I can be of any further assistance. More information on this topic can be found at www.oregondec.org/pse.htm.

Sincerely,

Rob Bovett
District Attorney, Lincoln County, Oregon
Legal Counsel, Oregon Narcotics Enforcement Association

enc: New York Times Op Ed (2 pages)
Drug Policy Bio (1 page)

[16] The tragedy and hazards of children in meth lab environments is well documented, both in the media and in studies. *See, e.g.,* the series of studies conducted by the National Jewish Medical and Research Center, copies of which are posted at: www.oregondec.org/documents.htm.

The New York Times

OP ED

How to Kill the Meth Monster

November 16, 2010
By ROB BOVETT

Newport, Ore.

THE latest bad news from the world of methamphetamine is that makers of the drug have perfected a one-pot recipe that enables them to manufacture their highly addictive product while on the move, often in their car. The materials they need — a two-liter soda bottle, a few cold pills and some household chemicals — are easily obtained and easily discarded, often in a trash bag dumped along the highway.

There is, however, a simple way to end this mobile industry — and, indeed, most methamphetamine production. We've tried it in Oregon, and have seen how well it works. Just keep a key ingredient, pseudoephedrine, out of the hands of meth producers.

Pseudoephedrine is a nasal decongestant found in some cold and allergy medicines. In 1976, the Food and Drug Administration allowed it to be sold over the counter, inadvertently letting the genie out of the bottle. Afterward, the meth epidemic spread across the nation, leaving destroyed lives and families in its wake.

Sales of products containing pseudoephedrine in the United States now amount to nearly $600 million a year. Yet, according to the pharmaceutical industry, only 15 million Americans use the drug to treat their stuffed-up noses, and these people typically buy no more than a package or two ($10 to $20 worth) a year.

Over the years, Congress and state legislatures have passed laws meant to prevent the diversion of pseudoephedrine to meth production. But such efforts have amounted to only temporary Band-Aids.

In 2006, Congress required pseudoephedrine products to be moved behind the counter, set daily and monthly limits on the amount that can be sold to any one customer and required retailers to keep a

log of sales. But meth users quickly learned to evade these controls by making purchases in several different stores — a practice known as “smurfing.”

In an effort to avoid having more stringent controls placed on the drug, the pharmaceutical industry is lobbying Congress to require electronic tracking of pseudoephedrine sales, as some states already do. This makes it harder for an individual smurfer to collect large quantities of the drug. But meth users get around the tracking system by banding together in cooperatives, with each member buying pseudoephedrine products in amounts small enough to evade detection. These group smurfers then contribute their portion to the pot in exchange for cash or a share of the cooked-up meth. Or, in the West, they feed the “super labs” run by drug trafficking organizations in Central California.

In Kentucky, an electronic tracking law that went into effect in 2008 has had no effect on the number of meth labs there, and only 10 percent of them are found by electronic tracking. The number of police incidents involving meth labs has actually increased by more than 40 percent.

The only effective solution is to put the genie back in the bottle by returning pseudoephedrine to prescription-drug status. That’s what Oregon did more than four years ago, enabling the state to eliminate smurfing and nearly eradicate meth labs. This is part of the reason that Oregon recently experienced the steepest decline in crime rates in the 50 states.

Earlier this year, Mississippi also passed a law requiring a prescription to get pseudoephedrine. Since July, the number of meth labs in that state has fallen by 65 percent.

In 2009, Mexico, which had been the source of most of the methamphetamine on the streets of the United States, went further, banning pseudoephedrine entirely. The potency of meth from Mexico has since plummeted. This is great news. But now the ball is back in our court.

These pseudoephedrine prescription requirements apply to only 15 pharmaceutical products and their generic equivalents — medicines like Sudafed 12 Hour, Aleve D and Advil Cold and Sinus. Most cold and allergy medicines on store shelves are not affected, because they contain no pseudoephedrine.

Senator Ron Wyden of Oregon has proposed legislation to require prescriptions for products with pseudoephedrine nationwide, and Congress should enact it without delay. American families, too many already devastated by the meth epidemic, deserve no less.

Rob Bovett, the district attorney for Lincoln County, Ore., was the primary author of Oregon’s anti-methamphetamine laws.

ROB BOVETT
District Attorney

KYLIE ANDRISA
Deputy District Attorney

JOE BECK
Deputy District Attorney

GWEN BEE
Deputy District Attorney

MICHELLE BRANAM
Deputy District Attorney

JILL WAGNER
Office Manager

OFFICE OF THE DISTRICT ATTORNEY
FOR LINCOLN COUNTY
225 WEST OLIVE STREET, ROOM 100
NEWPORT, OREGON 97365
541-265-4145, FAX 541-265-3461
www.co.lincoln.or.us/da/

MARCIA BUCKLEY
Chief Deputy District Attorney

JONATHAN CABLE
Deputy District Attorney

BRIAN GARDNER
Deputy District Attorney

ELIJAH MICHALOWSKI
Deputy District Attorney

NELLY WRIGHT
Deputy District Attorney

MARCIA THOMPSON
Victim Services Supervisor

Rob Bovett

Drug Policy Bio

- Currently serves as the elected District Attorney for Lincoln County, Oregon. Also serves as legal counsel for the Oregon Narcotics Enforcement Association (ONEA).

- Author of many of Oregon's drug laws, including those relating to meth lab control. Helped author federal laws to control international diversion of meth precursor chemicals.

- Served as Chair of Oregon's Meth Task Force, and currently serves on the Advisory Board of the National Methamphetamine & Pharmaceuticals Initiative (NMPI).

- Co-founder and President of the Oregon Alliance for Drug Endangered Children (OADEC).

- Created numerous local and state initiatives that provide science-based solutions to problems caused by substance abuse and mental illness, such as HOPE and other diversionary court programs.

- Authored a law review article entitled *Meth Epidemic Solutions*, 82 North Dakota Law Review 1195. Has authored numerous reports and published opinion pieces on drug policy topics.

- Has provided over 500 presentations regarding drug policy, and has appeared on numerous programs, including ABC World News, Good Morning America, National Public Radio, and PBS NewsHour and FRONTLINE.

- Recipient of the 2006 Oregon Governor's Gold Award for outstanding public service, and the 2008 NMPI national "Impact" award.

- Married, and has four adult children and one grandchild – so Rob is aging a bit faster than normal.