REPLY TO CASCADE'S RESPONSE

Friday, March 2, 2012

Cascade Policy Institute recently released a pharmaceutical industry-funded study which supports the views of the industry in regard to Oregon's law returning pseudoephedrine to a prescription drug. Cascade's Steve Buckstein also wrote an Op Ed trumpeting the study:
http://www.oregonlive.com/opinion/index.ssf/2012/02/oregons_cold_medicine_restrict.html

I wrote an Op Ed pointing out three fundamental flaws:
http://www.oregonlive.com/opinion/index.ssf/2012/02/pseudoephedrine_big_pharma_stu.html

Specifically, I challenged, and continue to challenge:

1. The use of federal meth lab incident data to compare meth lab incidents from state to state, because of wide variation among states in reporting meth lab incidents to the feds.
2. The failure of the study to address meth lab size, because currently in the West massive scale diversion of retail pseudoephedrine is taking place that does not feed thousands of small user meth labs like it used to, and like it currently does in many other parts of our nation. Currently, the massive diversion of retail pseudoephedrine here in the West (commonly known as "super smurfing") fuels "super labs" in central California run by major drug trafficking organizations.
3. The study's assertion of heavy burdens on Oregon consumers, business, and our health care system from our pseudoephedrine law, without citing any data, studies or reports to back up such an assertion.

On March 1, 2012, Cascade issued a response to my Op Ed:
http://cascadepolicy.org/pdf/pub/Responses_to_questions_about_data_source.pdf

Unfortunately, the response doesn't even try to address two of the major flaws in the study.

The Full Picture

1. Trends: At the time the Oregon law was implemented, the entire country was experiencing a downturn in meth lab incidents. In part, that was a direct result of many states realizing that access to pseudoephedrine was the key to controlling the meth lab epidemic. Around the same time, Congress enacted the Combat Methamphetamine Epidemic Act (CMEA), which moved all pseudoephedrine products behind the counter nationwide, and required identification and logging for each retail sale. For the next couple years, meth labs incidents continued to decline nationwide. But those of us who had been dealing with the problem for many years knew this was, at best, a temporary fix. The law had loopholes. The pharmaceutical industry knew this as well. One of the biggest issues we fought over during the passage of the CMEA was a preemption clause. The industry wanted the new federal law to prohibit any state from further restricting access to pseudoephedrine. But law enforcement knew better, and wanted to ensure a state's right to adjust controls if the loopholes proved true. Law enforcement wouldn't budge, and the CMEA was passed without the restriction on state's rights.

2. Collateral damage: In Oregon, we implemented CMEA style controls a couple years before the federal law, and meth lab incident numbers were coming down. That was a good thing. A lot of pseudoephedrine diversion had led to a lot of meth labs, which led to much collateral damage: Property and environmental contamination, burn victims, drug endangered children, violence, taxpayer money spent on clean-ups, social services, investigation, prosecution, incarceration, etc. This was the motivation for returning pseudoephedrine to a prescription drug. Not meth use.

3. Vaccination: Oregon wanted to prevent and inoculate itself from meth labs returning, and end a practice known as "smurfing," where groups of people each purchase lawful amounts of pseudoephedrine, later diverted to make meth. We could see that smurfers were already starting to get around our pseudoephedrine controls. Smurfing was too easy. I took four of our legislative leaders smurfing, and they showed their colleagues just how easy it was to evade our law. Other states, most notably Oklahoma, decided they wanted to get vaccinated as well. But they took a different route, namely electronic tracking of pseudoephedrine sales. The results are clear. Returning pseudoephedrine to a prescription drug eliminates smurfing. Electronic tracking does not. That is the key point. Smurfing has surged in other states, just like we predicted. But not in Oregon. Virtually all domestic meth labs are now fueled by the diversion of pseudoephedrine from retail sales. Smurfing cannot and has not taken hold in Oregon. Oregon is immune. In the West, states around California, with the exception of Oregon, are plagued with "super smurfing," which fuels the large super labs in central California run by drug trafficking organizations. Oregon has immunized itself from that as well. In other words, Oregon is no longer a part of that problem.

4. Meth from Mexico: Any objective study has to first recognize the sources of meth. There are basically two: Domestically manufactured meth, and meth made in Mexico. But they aren't the same kind of meth. Some studies miss, or ignore, this important distinction. Almost ninety percent of the meth coming from Mexico today is not made from pseudoephedrine, because Mexico has banned pseudoephedrine entirely. As a result, Mexican meth is substantially less potent than meth made here in America from pseudoephedrine. This is incredibly important, and was skipped or ignored by the Cascade study. While meth use is still present after pseudoephedrine is returned to a prescription drug, it is predominantly the weaker meth from Mexico. Further, if law enforcement doesn't have to spend valuable time chasing smurfers or taking down meth labs, they have more time to better serve the public, for example going after major drug dealers, burglary rings, etc.

Reputable studies should not rely on statistics alone. Sometimes statistics can mislead, or in this case fail to tell the rest of the story. Researchers should also consult the experts, just to ensure their study doesn't reach an absurd or misleading conclusion. A failure to do so can call into question the true motive of the study, or the results. It's not too late. They just have to ask.

If Cascade or others would like an introductory primer on what Cascade missed, I would encourage them to start with a review of the written testimony of Kent Shaw from California BNE before the Nevada Legislature last year: http://www.oregondec.org/NV/Testimony-KS.pdf

The Cascade study was, and remains, fatally flawed. It parrots misleading information used by the pharmaceutical industry around the Nation, and ignores key facts. The study was written to support a pre-existing position. It was predestined to be flawed. It can be corrected, but Cascade must first be open to learning. If they refuse to learn from the experts, then they invite the conclusion they are being driven by their own predetermined results, or by the client who paid for the study.

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For more information, visit www.oregondec.org/pse.htm