The Combat Meth Act of 2005:
Addressing the Methamphetamine Crisis through Regulation

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Introduction

A long time "niche drug among West Coast biker gangs," methamphetamine use in the United States grew in the 1990's, reaching an estimated 1.4 million Americans by 2003 (Frontline, 2006). Much of this growth was a result of the rise in "clandestine" meth labs, small-time operations functioning as "ad hoc laboratories in backwoods shacks, out-of-the-way hotel rooms, and just about anywhere else you can cram in a supply of hot plates, glassware, and noxious chemicals necessary to make meth." (151 Cong. Rec. S9972 (daily ed. Sep. 13, 2005) (statement of Sen. Talent)) These labs produce methamphetamine by using easily available substances, the active ingredient being pseudoephedrine, a widely used over the counter decongestant medication. As a result, there was a growing fever to regulate the sale of pseudoephedrine to limit the ability of clandestine lab operators to source ingredients to produce their methamphetamine.

In 2005, the Combat Meth Act (CMEA) was passed as Title VII of the USA PATRIOT Improvement and Reauthorization Act, an omnibus piece of legislation designed to bolster national security which expanded on and modified the original USA PATRIOT Act of 2001 which was passed in response to the attacks on September 11th the CMEA aimed to curb the growing production and use of methamphetamine by limiting and regulating the sale of several different over-the-counter drugs, namely pseudoephedrine (Sudafed) and its variants (151 Cong. Rec. S9973 (daily ed. Sep. 13, 2005) (statement of Sen. Alexander)).

Congress placed both daily and monthly caps on individuals' purchases of pseudoephedrine and related products, with a 3.6 gram per day and 9 grams per 30-day period. It also put in place requirements for vendors to move the products off the shelves making them "behind the counter," verify identification, and track the quantity and volume of products purchased.

Descriptive Analysis

Private Sector

The CMEA is interesting as it comes to government policy, as the on-the-ground implementation of the new regulations fell almost entirely on the private sector, with retailers specifically being responsible for much of the implementation. In pursuit of the main objective of limiting these clandestine labs manufacturing methamphetamine, the CMEA consisted of two main pillars: restriction and tracking.

It was the responsibility of retailers to prevent free customer access to the drugs and ensure that purchases were logged and tracked. Retailers achieved the former requirement either by having a space behind the counter where they would be stored or by installing a locked cabinet in the customer area for their storage, which satisfied the requirement that they "deliver product directly into the custody of the purchaser." (Department of Justice, 2006) They satisfied the latter requirement by keeping a list of sales either electronically or in writing that tracked the products and quantity sold, the name and address of the purchaser, and the date and time of the sale. They were also made responsible for training their employees in the new requirements and processes for the sale of the newly regulated drugs, and were not permitted to sell the products if these trainings were not conducted and the self-certification submitted to the Department of Justice (DOJ).

Government- Federal Administration

The government agency primarily responsible for the implementation of the restrictions in the CMEA was the DOJ in general, and often more specifically the Drug Enforcement Agency (DEA).The Attorney General was the individual that handled the majority of the oversight on the

specific policy and regulations contained in the CMEA. The CMEA charged the Attorney General with the responsibility of ensuring that all retail employees that would be selling these newly regulated products were properly trained. The Attorney General was required to create an internet-based mechanism by which retailers could submit and maintain their self-certifications of employee training.

Though the logging of individual sales was the responsibility of retailers, the tracking and enforcement of the limits was the responsibility of the DOJ. In partnership with state and local officials, the DOJ was to carry out investigations into the over-purchase of these drugs and the potential resulting methamphetamine production operations.

Government- Local

A small portion of the implementation was laid on local governments, particularly the actual law enforcement actions. In the cases where an individual purchased an amount over the prescribed limit and the DOJ was not already involved or suspicious, the arrest and initial investigation was commonly done by local law-enforcement action (Barrilleaux, 2007; Sullum, 2009, 2014). In the intervening period, several states have passed their own more restrictive limits on the sale of these drugs, and therefore state and local law enforcement is involved with the implementation of these laws as well (Ydstie, 2005; Drug Abuse Prevention and Control, Title XLVI Florida Statutes § 893.1495).

Government- Congress

Many provisions of the USA PATRIOT Act of 2001 contained “sunset provisions,” provisions which were not indefinite and would cease to be in effect after 4 years. Therefore

every several years, Congress has the choice to either let those provisions expire or pass a new law to extend and amend these and other provisions of the Act. Since the passage of the USA PATRIOT Improvement and Reauthorization Act of 2005, Congress has continued to improve and reauthorize various provisions of the original USA PATRIOT Act of 2001, though Title VII of the 2005 act, which contained none of these sunset provisions, has stayed in place. Congress has continued to monitor the methamphetamine crisis and general drug epidemic.

Evaluation of Implementation

The primary criteria we will be focusing on to evaluate the implementation of this policy is the raw statistical data. We will be searching for statistics on overdose rates, illegal lab busts, over the counter sales, and examining over the border consumption of methamphetamine. We will be examining these criteria through the lens of the societal problem of drug abuse and addiction, examining the policy's effects on drug use, comparing pre- and post-implementation numbers.

Overdoses

Drug overdose was the leading cause of injury death in the United States in 2016 (DEA, 2016). In 2020, overdoses of psychostimulants with abuse potential, primarily methamphetamine, rose to 23,837. Drug overdoses rose from 547 in 1999 to 23,837 in 2020. The number of deaths involving psychostimulants have steadily risen since 2014, regardless of opioid involvement (CDC Wonder). There were 91,799 drug-involved overdose deaths in 2020 (NIDA, 2022). Utilizing this data, we can see that overdose deaths involving methamphetamine accounted for approximately 26% of all overdose deaths in 2020. The number of overdose deaths involving methamphetamine increased fourfold between 2015 and 2020.

Methamphetamine use surged during the 8-year period of 2011-2018. The overdose deaths of Non-Hispanic Alaskan Natives/American Indians ages 25-54 increased fourfold in this period, the largest increase of any racial group. Men have been dying at a higher rate from drug overdoses than women in every racial/ethnic group. Unfortunately, there has been exceptionally high overdose rates among American Indians and Alaskan Natives, with women in these ethnic groups dying at higher rates than non-Hispanic Black, Asian, and Hispanic men (NIDA, 2021).

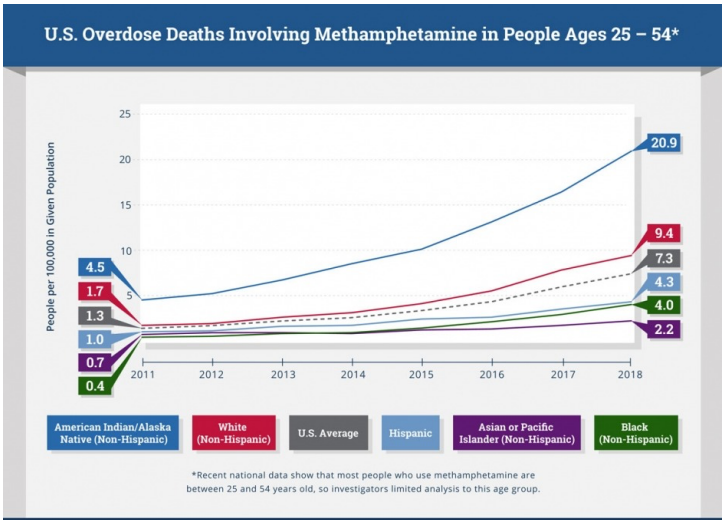


Figure 6. National Overdose Deaths Involving Psychostimulants with Abuse Potential (Primarily Methamphetamine)*, by Opioid Involvement
Number Among All Ages, 1999-2020

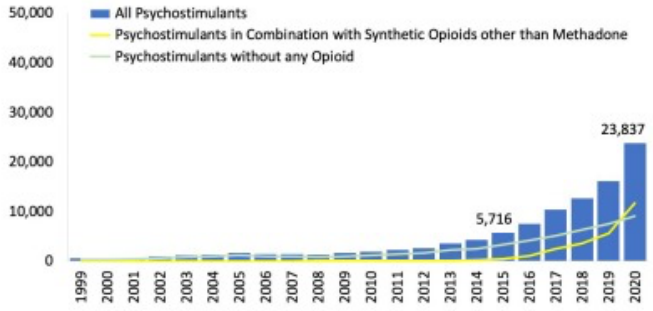
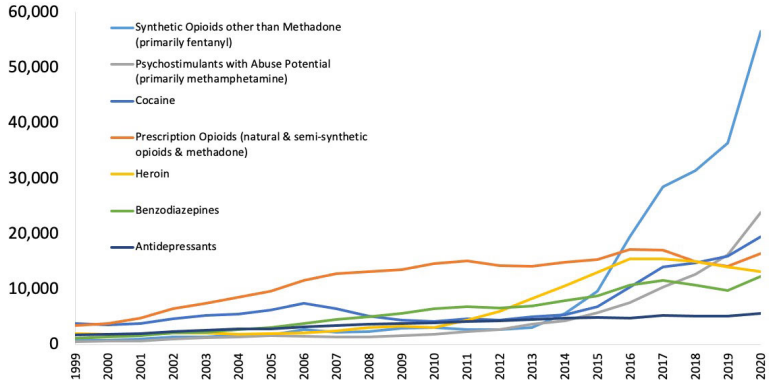


Figure 2. National Drug-Involved Overdose Deaths*,
Number Among All Ages, 1999-2020



Illegal Lab Busts

The National Drug Intelligence Center (NDIC) created an informational page regarding the dangers of methamphetamine laboratories, including ingredients that can be used to make meth and possible equipment that would be used in meth production, as an attempt to get citizen participation in the seizure of illegal drug labs. According to the NDIC, a methamphetamine laboratory is "an illicit operation that has the apparatus and chemicals needed to produce the powerful stimulant methamphetamine" (NDIC, 2003). According to the NDIC fact page, over 7,500 meth labs were busted across 44 states in 2002 alone.

According to the Obama White House archives, the enactment of the CMEA has seen a decrease in meth use in the United States, however there has been an increase in lab incidents. Several states implemented laws that require a prescription for pseudoephedrine, which resulted in fewer lab incidents and related arrests in states like Oregon. Online logging systems for sales has allowed the government to block thousands of sales and led to 70% of the lab busts across several counties in states such as Kentucky (Obama White House Archives, 2010). Despite the CMEA passage, the number of domestic meth labs has increased recently (according to 2010 standards). A process known as "smurfing" had been used by traffickers, in which they sent multiple individuals to several retailers throughout the day to purchase the daily limit of pseudoephedrine, because the CMEA did not require sales logs to be electronically connected.

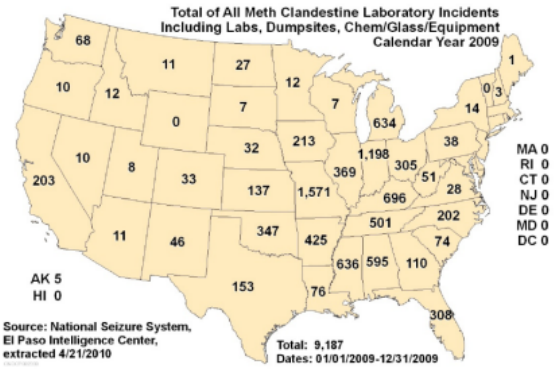
Despite the best intentions, it was still relatively easy for criminal groups to obtain large amounts of pseudoephedrine legally on a daily basis.

The UN Office of Drug Consumption has collected excellent research on drug manufacturing at an international scale, reported in the World Drug Report of 2010. Of amphetamine-type synthetics (ATS) laboratory production, the most commonly produced drug is methamphetamine, because of its simplicity to produce.

Over the Counter Sales

According to the CMEA, an individual cannot purchase more than 3.6 grams of pseudoephedrine in a single day, and no more than 9 grams in a 30-day period. Since the implementation of the CMEA, these statutes have remained in place and have maintained the desired restrictions on pseudoephedrine sales.

Over the Border Imports (non-Domestic production)



The U.S. Customs and Border Protection has reported yearly drug seizures by category of drug and weight over the past decades. In 2020, 178k pounds of methamphetamine was seized, 2021 resulted in 192k pounds of meth seizure, and 2022 has pulled 175k pounds thus far. Courtesy of drugabuse.com, the DEA reports that Mexican drug trafficking organizations are the largest international suppliers of heroin, cocaine, marijuana, and methamphetamine that crosses the U.S. border (Thomas, 2022). In 2016, 6 drug types accounted for nearly all drug trafficking

offenses, with methamphetamine at the highest rate- 33.6% of all trafficking cases (U.S. Sentencing Commission, 2016). Trafficking operations have continued to evolve with changing technology, including using social media to communicate during drug shipments. The primary concern for law enforcement officials regarding the international drug trade is the adulteration of drugs. When drugs are received in the U.S., a dealer/supplier/middleman will take the blocks of drugs to a secure location and cut up the drugs into regular doses, sometimes mixing in other ingredients from caffeine to fentanyl, leading to higher rates of overdose as the user often does not know that the drugs they purchased had been cut with another substance.

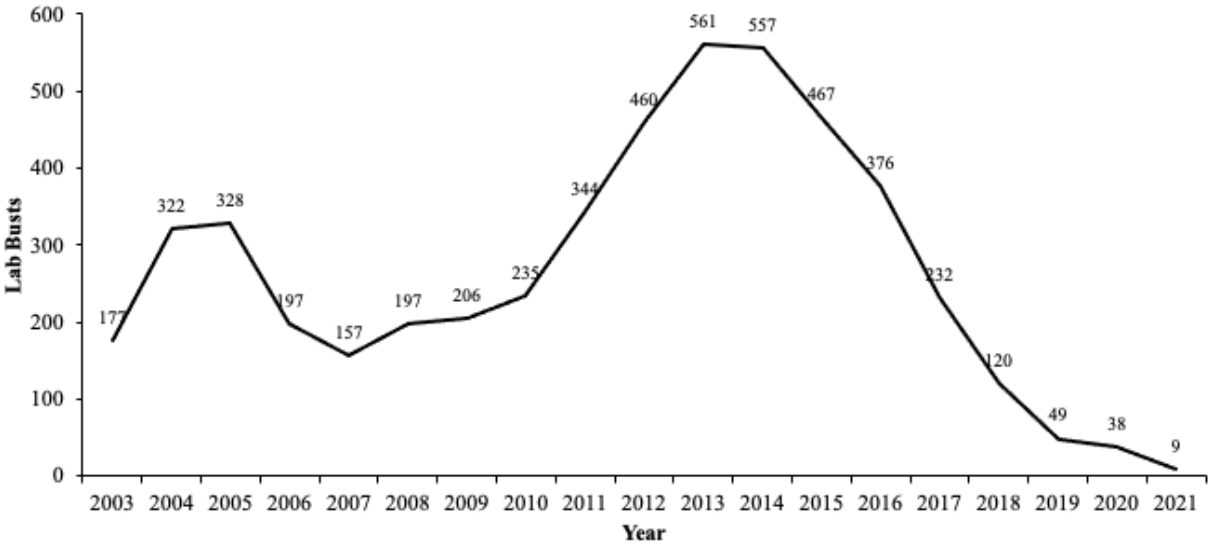
Causal Analysis of Implementation

Success of the CMEA should be judged by the extent to which its goals were achieved. The CMEA had four discernable goals: to restrict and limit the sale of pseudoephedrine and related products, curb the use of methamphetamines, reduce the number of methamphetamine-producing clandestine labs, and limit the drug epidemic.

For the first goal of the CMEA, i.e. making sure the purchase restrictions on pseudoephedrine and related products, implementation was a definite success. This success is driven by the design of the policy. By putting the obligation of implementation largely on the private sector, the government used the market as a tool to force implementation. Though in a vacuum retailers would not have supported or elected to carry out these regulations, the drive for additional profits forced them to. Had retailers not enforced the CMEA, they would not have been allowed to sell the products at all. Therefore, wanting to continue carrying these popular products and making a profit from them, retailers abided by the CMEA.

The higher-order goals of the CMEA, reducing methamphetamine use & clandestine labs producing methamphetamine and tamping the drug epidemic, has more mixed results. The use of methamphetamines in the United States did fall in the years following the implementation of the CMEA, though it began increasing in the years following 2010 (Obama White House Archives, 2010). Similarly, the number of lab busts decreased significantly following 2005, and began rising again in 2010. Also supporting the idea that the CMEA reduced domestic production of methamphetamines by clandestine labs is the increasing amount of methamphetamine that is coming into the country via its borders. Domestic production capacity falling forced distributors to turn to outside entities. Figure A shows the number of lab busts in North Carolina by year from 2003 to 2021.

Figure A: Meth Lab Busts in North Carolina by Year (2003-2021)



Source: North Carolina State Bureau of Investigation

The overall drug epidemic however, even in the short period following the passage and implementation of the CMEA, has not improved. Though largely driven by other drugs, particularly opiates and other synthetic drugs in recent years, methamphetamine use is on the rise, as Figure 2 showed.

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