March 10, 2017

Judge William H. Pryor, Jr., Chair
United States Sentencing Commission
One Columbus Circle, N.E., Suite 2-500
Washington, DC 20002-8002

RE: Request for Public Comment (BAC 2210-40) - Synthetic Drugs

Dear Judge Pryor:

The Drug Policy Alliance appreciates this opportunity to provide comments as the Commission undertakes a two-year study of MDMA (3,4-Methylenedioxy-Methamphetamine) and novel psychoactive substances (NPS), specifically MDPV (Methylenedioxypyrovalerone), Methylone (3,4-Methylenedioxy-N-Methylcathinone), Mephedrone (4-Methylmethcathinone (4-MMC)), JWH-018 (1-Pentyl-1-3-1-(1-Naphthoyl)Indole) and AM-2201 (1-(5-Fluoropenty1)-3-(1-Naphthoyl)Indole) with the intention of determining whether amendments to the Guidelines Manual may be appropriate for criminal offenses involving these substances.

The Drug Policy Alliance (DPA) works to increase the degree to which drug use is treated as a health issue and advances evidence based drug policy grounded in compassion and human rights. We accordingly oppose policies that predominantly rely on the criminal justice system to address drug use. DPA educates lawmakers at both the federal and state level about illicit drugs and effective policy responses that reduce harms both from drug use and drug prohibition.

In 2016, DPA co-hosted a summit in New York titled *New Strategies for New Psychoactive Substances*, which brought together more than 30 scholars, activists, service providers and people who use drugs to share what is currently known about NPS, identify areas for future NPS research, discuss strategies for intervening when NPS use becomes harmful and for new forms of NPS drug regulation, and explore how messaging and media about NPS can become more constructive.[1] Some of the findings from this convening are reflected in these comments.

People use NPS for a multitude of reasons, not least of which to cope with everyday struggles and experience pleasure. There are anecdotal reports that some people use synthetic cannabinoids and other NPS as a replacement therapy to manage withdrawal from heroin and other substances. Since NPS are generally not detectable by most conventional drug screening panels, many individuals also use NPS as a substitute for marijuana and other illicit substances that are prohibited as a condition of maintaining employment, court-ordered supervision or access to services.

We are the Drug Policy Alliance.

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People are known to use NPS to maintain employment, including individuals working in occupations where drug testing is routine such as law enforcement and military service. Drug testing is often a condition of receiving social services such as temporary housing and public assistance, which can incentivize people who rely on these services and have a substance use disorder to substitute NPS for illicit drugs or alcohol. The same holds true for individuals who are under court-ordered supervision and must submit to drug testing as a condition of probation or parole or are subjected to drug testing as a condition of remaining enrolled in substance abuse treatment.

NPS use has been documented among law enforcement and military ranks and in other professions, in both rural and urban communities and across socioeconomic groups. However, the media's portrayal of people who use NPS has skewed toward some of the most visible people in society and especially in urban centers. Individuals who are homeless or lack permanent housing and who often suffer from co-occurring substance use and mental health disorders are heavily profiled by the media. Sensationalist and dehumanizing media reports of "zombies" highlight extreme cases that have heavily influenced policymakers' efforts to criminalize these substances.

Prohibition is driving the rapid emergence of new NPS compounds that are exacerbating dangers to public health. Banning NPS compounds by placing them in Schedule I of the federal Controlled Substances Act has not stopped manufacturers from selling banned substances - such as those under review by the Commission - or creating new compounds that skirt existing laws. Criminalization only incentivizes manufacturers to invent new substances to replace what was banned. As this process repeats, chemical compounds are manipulated in ways that have never been studied for their health effects, potentially increasing – not mitigating - the dangers to public health.

Packages of NPS are sold under many different names and can contain a variety of chemical compounds sprayed on plant leaves with varying levels of potency. Because NPS are constantly changing, people cannot know which exact drugs they are taking, how the drugs will physically or emotionally affect them, or how they will interact with medications and other substances. Law enforcement may argue that the rapid evolution of these substances warrants harsher sentences and more aggressive prohibition. This, however, is exactly what incentivized the production and marketing of synthetic cannabinoids and synthetic cathinones as a legal alternative to illicit substances.

How the Commission may decide to set guidelines with respect to the NPS compounds currently under review will influence lawmakers at both the federal and state level who must make policy decisions about NPS. A decision to make sentencing guidelines for offenses involving the specified NPS

compounds excessively punitive could influence lawmakers to pursue more aggressive criminalization with serious consequences.

Since Congress last added NPS compounds to Schedule I in 2012, hundreds of new chemical compounds have been created and distributed for sale in the United States. The Drug Enforcement Administration has also added NPS compounds to Schedule I using both its emergency scheduling and rulemaking authority. Each compound added to Schedule I triggers the application of federal drug sentencing laws. Because there a lack of common understanding as to what constitutes an ordinary psychoactive dose for many of these NPS compounds, Congress has not specified quantity triggers, meaning people who struggle with addiction can face draconian sentences for miniscule amounts of any substance added to Schedule I.

Criminalization can also exacerbate health risks from using drugs, by pushing risky behavior underground and making it more difficult for health authorities to study impacts on public health and get help to people who need it the most. A Schedule I designation also erects regulatory and funding barriers to research that make it far more difficult for researchers to get support from their sponsoring institutions to investigate controlled substances.

Criminalizing people who use and sell drugs can also amplify the risk of fatal overdoses and diseases, increases stigma and marginalization, and drives people away from needed treatment, health and harm reduction services. For example, fear of arrest is the most common reason that witnesses do not immediately call 911 in the event of an overdose.[2] The stigmatization of people who use and sell drugs is pervasive in society and it creates major barriers to treatment, health care and other vital services.[3]

Moreover, the use of scarce government funds to enforce, prosecute, and incarcerate people who use NPS substances puts further strain on criminal justice resources. The criminalization of people who use drugs is also a major driver of mass arrests in the United States. Each year, U.S. law enforcement makes more than 1.5 million drug arrests – more arrests than for all violent crimes combined. The overwhelming majority – more than 80 percent – are for possession *only*.[4] Year after year, more than a million people are caught in the criminal system for nothing more than drug possession or use.[5]

Black people are far more likely to be arrested for drug possession and use, even though rates of reported drug use do not differ substantially among people of different races and ethnicities.[6] Disparate enforcement of drug possession laws and harsh sentencing requirements have produced profoundly unequal outcomes for people of color, who experience discrimination at every stage of the judicial system.

People who are incarcerated are held in environments where risks of contracting or transmitting HIV and hepatitis C are greatly elevated, with insufficient testing, prevention, treatment and other public health services.[7] Many jails and prisons in the U.S. do not provide medically supervised or medication-assisted withdrawal.[8] Even after a person completes a period of incarceration, a criminal conviction for drug possession can result in the temporary or permanent loss of child custody, voting rights, employment, business loans, licensing, student aid, public housing and other public assistance. These "collateral consequences" of drug convictions intensify the struggles individuals face on the road to recovery and rehabilitation.

The most effective way to reduce harms associated with NPS are harm reduction and treatment programs, which connect people to services – especially housing and employment. There are other potential approaches to regulating NPS use other than outright prohibition and criminalization. In July 2013, New Zealand's parliament enacted a historic law that created an FDA-like process for approving NPS if their relative safety can be demonstrated. While the outlines of the law are unique to New Zealand, it is one example of a different approach to a public health issue. We also believe that demand for synthetic cannabinoids and other NPS could decrease precipitously if people could get legal and regulated access to marijuana.

The Commission is weighing what the specified NPS compounds actually do and which existing scheduled drug is "the most closely related controlled substance" to these NPS compounds for the purposes of sentencing a person to a term of incarceration. Apart from anecdotal reports from law enforcement, emergency room physicians, and limited data from government surveys and exposure reports from poison control centers, little is actually known about NPS and much of the existing research on NPS does not reflect the experiences of people who use drugs or the on-the-ground reality of why and how people are using NPS and their effects. Little is known about the substances themselves, their effects, the epidemiology of their use, or interventions and policies to reduce their harms.

Similarly, little is known about the "potential for addiction and abuse, the pattern of abuse and harms associated with abuse" of NPS, including those compounds that are the focus of the Commission's two-year study. The actual risk profile of various NPS are not well known. There is insufficient data on prevalence and the effects of these substances on health to definitively understand the risks associated with use.

It is our view that the Commission's evaluations of the specified NPS compounds under its review should be informed by epidemiological research that surveys a broad population to better understand how widespread the use of NPS is as well as adverse effects from using these substances. Ethnographic research is also needed to understand the range of reasons why

people choose NPS over other substances, exactly how they are using them, and what factors impact choices to use or not use NPS. Decisions regarding the appropriate sentencing guidelines should be based on the best possible and most rigorous science.

We appreciate the difficulty of determining an appropriate response to NPS within the Commission's mandate to set sentencing guidelines for scheduled substances. However, we urge the Commission to seek and consult the best possible science before making determinations about how the specified NPS compounds may be addressed in the Sentencing Guidelines. We also urge the Commission to consider the impact that these determinations will have on policymakers who must respond to the rapidly evolving nature of NPS.

With respect to the Commission's review of current Sentencing Guidelines for MDMA, we concur with Rick Doblin, Ph.D., in prepared testimony on behalf of the Multidisciplinary Association of Psychedelic Studies (MAPS),[9] that the Commission's decision to increase the mandatory minimum sentences for MDMA-related offenses in 2001 was not guided by science. Rather, this decision was informed by the same kinds of anecdotal and sensationalized information that has guided most NPS policy decisions in the United States. We believe that the MDMA Sentencing Guideline is excessively punitive and inappropriate given both what is known scientifically about the drug as well as its known therapeutic value. We urge the Commission to adjust the MDMA Sentencing Guideline downward to reflect these findings.

Thank you for considering our views,

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[1] A full program of the *New Strategies for New Psychoactive Substances* event can be found here: http://www.drugpolicy.org/sites/default/files/documents/Psychoactive_NPS_Program.pdf, and videos of the sessions are here: https://www.youtube.com/playlist?list=PLf6y9tNpg8wMugyNNxppsE_GPxBzXHM69.

[2] See Peter J. Davidson et al., "Witnessing Heroin-Related Overdoses: The Experiences of Young Injectors in San Francisco," *Addiction* 97, no. 12 (2002); S. E. Lankenau et al., "Injection Drug Users Trained by Overdose Prevention Programs: Responses to Witnessed Overdoses," *J Community Health* 38, no. 1 (2013); M. Tracy et al., "Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention," *Drug Alcohol Depend* 79, no. 2 (2005); K. C. Ochoa et al., "Overdosing among Young Injection Drug Users in San Francisco," *Addict Behav* 26, no. 3 (2001); Robin A. Pollini et al., "Response to Overdose among Injection Drug Users," *American journal of preventive medicine* 31, no. 3 (2006).

[3] Samuel R. Friedman et al., "Drug Arrests and Injection Drug Deterrence," *American Journal of Public Health* 101, no. 2 (2011): 344-49; S. R. Friedman et al., "Relationships of Deterrence and Law Enforcement to Drug-Related Harms among Drug Injectors in Us Metropolitan Areas," *AIDS* 20, no. 1 (2006): 93-99; Corey S. Davis et al., "Effects of an Intensive Street-Level Police Intervention on Syringe Exchange Program Use in Philadelphia, Pa," *American Journal of Public Health* 95, no. 2 (2005): 233-36; D. Wolfe, M. P. Carrieri, and D. Shepard, "Treatment and Care for Injecting Drug Users with Hiv Infection: A Review of Barriers and Ways Forward," *Lancet* 376, no. 9738 (2010): 355-66; E. Wood et al., "A Review of Barriers and Facilitators of Hiv Treatment among Injection Drug Users," *AIDS* 22, no. 11 (2008): 1247-56.

[4] Federal Bureau of Investigation, "Crime in the United States, 2014," (Washington, DC: U.S. Department of Justice, 2015). The number of drug arrests first exceeded 1.5 million in 1996 – and it has almost never fallen below that point since.

[5] Sean Rosenmerkel, Matthew Durose, and Jr. Donald Farole, "Felony Sentences in State Courts, 2006-Statistical Tables," (Washington, D.C.: Bureau of Justice Statistics, 2009), Tables 1.1 & 1.2.

[6] *See, for example,* National Research Council, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, D.C.: The National Academies Press, 2014).

[7] Thomas Kerr, Will Small, and Evan Wood, "The Public Health and Social Impacts of Drug Market Enforcement: A Review of the Evidence," *International Journal of Drug Policy* 16, no. 4 (2005): 210-20; S. A. Strathdee et al., "Hiv and Risk Environment for Injecting Drug Users: The Past, Present, and Future," *Lancet* 376, no. 9737 (2010). 268-284; Alex Stevens, "Applying Harm Reduction Principles to the Policing of Retail Drug Markets," (International Drug Policy Consortium, 2013); B. M. Mathers et al., "Hiv Prevention, Treatment, and Care Services for People Who Inject Drugs: A Systematic Review of Global, Regional, and National Coverage," *Lancet* 375, no. 9719 (2010); Global Commission on Drug Policy, "The War on Drugs and Hiv/Aids: How the Criminalization of Drug Use Fuels the Global Pandemic.," (2012).

[8] Legal Action Center, "Confronting an Epidemic: The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction," March 2015, https://lac.org/wp-content/uploads/2014/07/LAC-The-Case-for-Eliminating-Barriers-to-Medication-Assisted-Treatment.pdf (accessed September 22, 2016), p. 6; Amy Nunn et. al., "Improving Access to Opiate Addiction Treatment for Prisoners," Addiction, vol. 110 (7) (Jun. 2010), p. 1312; Shannon Gwin Mitchell et. al, "Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users," Journal of Psychoactive Drugs, vol. 41(2) (June 2009), p. 145–152.

[9] Rick Doblin, Ph.D., Testimony to US Sentencing Commission Re: MDMA, Multidisciplinary Association for Psychedelic Studies, March 15, 2017