UNITED STATES SENTENCING COMMISSION

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ALTERNATIVES TO INCARCERATION COURT PROGRAMS
AND SYNTHETIC DRUGS

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PUBLIC HEARING

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TUESDAY
APRIL 18, 2017

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The Commission met in U.S. Sentencing Commission Conference Room, Suite 2500, One Columbus Circle, N.E., Washington, D.C., at 9:00 a.m., William H. Pryor, Acting Chair, presiding.

PRESENT

WILLIAM H. PRYOR, Acting Chair
RACHEL E. BARKOW, Commissioner
CHARLES R. BREYER, Commissioner
DANNY C. REEVES, Commissioner
PATRICIA SMOOT, Commissioner
JONATHAN WROBLEWSKI, Commissioner

ALSO PRESENT

TERRENCE L. BOOS, Ph.D.
DR. JOHN CUNHA, DO
RICK DOBLIN, Ph.D.
PROFESSOR GREGORY DUDLEY, Ph.D.
HONORABLE DOLLY M. GEE
HONORABLE BRUCE HENDRICKS
DAVID C. LEDWITH, Office Manager, USSC
SHONTAL LINDER, Ph.D.
ALEX MAISEL, Staff Attorney, USSC
VANESSA PRICE, Professor, George Mason University
LISA RAWLINGS, Ph.D.
HONORABLE LEO SOROKIN
FAYE TAXMAN, Ph.D.
CAPTAIN OSVALDO TIANGA
ERIC WISH, Ph.D.

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P-R-O-C-E-E-D-I-N-G-S

9:13 a.m.

ACTING CHAIR PRYOR: Good morning. Welcome to the public hearing of the United States Sentencing Commission on two important issues, alternatives to incarceration in the federal court system and synthetic drugs.

I want to extend a warm welcome to our witnesses and to the public audience that joins us, both here in the District of Columbia and by live stream via our website.

Before we get started, I want to introduce other members of the Commission, and I'm pleased to say that we now have four voting members of the Commission.

Seated next to me is Rachel Barkow, who joined the Commission with me in 2013. Commissioner Barkow is the Segal Family Professor of Regulatory Law and Policy at the New York University School of Law, and serves as the faculty director of the Center on the

Administration of Criminal Law at the law school.

When the terms of Chair Patti Saris, Judge Charles Breyer, and Dabney Friedrich expired at the end of the last Congress, Commissioner Barkow and I were the only two remaining voting Commissioners. But on March 21st, the Senate confirmed two additional voting Commissioners.

Judge Breyer has served as a District Judge for the Northern District of California since 1998. He initially joined the Commission in 2013 and has now begun a second term. Welcome back, Judge Breyer.

COMMISSIONER BREYER: Thank you.

ACTING CHAIR PRYOR: We missed you. Judge Danny Reeves was appointed to a first term and is the newest member of the Commission. Judge Reeves is a District Judge for the Eastern District of Kentucky and has served in that position since 2001.

Before his appointment to the bench,

Judge Reeves practiced civil litigation in Lexington, Kentucky for 18 years. Judge Reeves, welcome to the Commission.

Patricia Smoot serves as the ex-officio Commissioner from the United States Parole Commission. Commissioner Smoot joined the Commission in 2010, and she became Chair in May 2015.

Finally, Jonathan Wroblewski serves as the ex-officio Commissioner from the Department of Justice. Commissioner Wroblewski has returned as the Director of the Office of Policy and Legislation in the Criminal Division of the department, after serving as the principal deputy assistant attorney general for the Office of Legal Policy. Welcome back, Jonathan.

COMMISSIONER WROBLEWSKI: Thank you. Nice to be back.

ACTING CHAIR PRYOR: Although the Commission again has four voting members, who are the four voting members required to promulgate

guideline amendments, the lack of a voting quorum for almost three critical months of our amendment cycle means we will not be able to promulgate amendments this year.

Those who closely follow us know that in December we voted to publish several proposed amendments for comment, among them, an amendment that would add a downward adjustment, encourage the use of alternatives for some first-time offenders, and amendments that would respond to recommendations made by the Tribal Issues Advisory Group regarding how tribal offenses and juvenile sentences are considered.

The public comment period has closed. We've received a great deal of thoughtful public comment, which can be reviewed on our website. We thank the public for taking the time to give careful consideration to these proposals.

Ordinarily, we would have received testimony about the proposed amendments at public hearing in March, but with only two voting

Commissioners, we deferred scheduling a hearing until a re-constituted Commission was formed.

By statute the Commission is required to submit any amendments to the guidelines to Congress by May 1st, for a 180-day Congressional review period. Because we did not have a voting quorum for almost three months, there simply was not enough time for us to schedule a proposed hearing -- public hearing on the proposed amendments, digest the public comment, deliberate and hold a public vote by the statutory deadline.

Therefore, this year we will not promulgate any amendments to the guidelines, but our data analysis, legal research and public comment on these proposed amendments should provide us a sound basis for considering guideline amendments as early as possible during the next amendment cycle.

Before turning to the topics of our hearing, I would like to update you on some of our other ongoing activities.

In March, the Commission released its 2016 annual report and source book of Federal Sentencing Statistics. The source book is a comprehensive compilation of sentencing data on every felony and Class A misdemeanor sentence in the federal courts.

In fiscal year 2016, there were 67,742 cases reported to the Commission, down 4.6 percent from 71,003 in fiscal year 2015.

The Commission continues to collect and report sentencing data on retroactive application of the 2014 drug guidelines amendment, often referred to as "drugs minus two". As of last December, federal courts had considered 44,529 motions for retroactive application of the 'drugs minus two' amendment, and the courts granted 29,872 or 67.1 percent of them.

In addition, the Commission continues to publish new findings from its multi-year study of recidivism among the federal offender

population. In February, we released a report examining 10,888 federal drug traffickers released in 2005.

The Commission found that, over an eight year follow up period, one half of federal drug traffickers were re-arrested for a new crime or re-arrested for a violation of supervised release.

That figure is similar to the recidivism rate for federal offenders overall, but significantly lower than the five-year recidivism rate of 76.9 percent for state drug offenders reported by the Bureau of Justice Statistics.

In March, the Commission released the third installment of our recidivism series. The report examines in further detail, the strong association between an offender's criminal history calculation under the guidelines and their risk of recidivism.

Finally, I'd like to remind everyone

about our annual national seminars on the Federal Sentencing Guidelines.

The Commission will hold two national programs, the first in Baltimore, Maryland, May 31st through June 2nd, and the second in Denver, Colorado, September 6th through the 8th. Registration for both seminars is open on the Commission website. The seminars will provide training to probation officers, prosecutors and defense attorneys.

Our public hearing today focuses on two multi-year policy priorities. First, we will hear from a panel of speakers about several programs in the federal court system, designed to promote alternatives to incarceration, then we will move to a topic of current concern, synthetic drugs. We will hear testimony from experts on synthetic drugs, including their chemical structure, pharmacological effects, trafficking patterns and community impact. We looked forward to a thoughtful and engaging

discussion.

So, first we're going to hear from Vanessa Price. Ms. Price is the director of the National Drug Court Institute, which is the primary training and technical assistance division of the National Association of Drug Court Professionals.

Ms. Price has provided drug training to numerous drug court programs nationwide and abroad on topics related to substance abuse, drug testing, recovery related services and program training, development and implementation.

Next will be Dr. Faye Taxman. Dr. Taxman is a professor in the criminology, law and society department and the Director for the Center for Advancing Correctional Excellence at George Mason University.

Dr. Taxman specializes in designing and evaluating evidence-based court programs and interventions. Ms. Price?

MS. PRICE: Good morning. My name is

Vanessa Price. I'm the Director of the National Drug Court Institute at the National Association of Drug Court Professionals.

Prior to assuming my role as the director, I retired after 22 years in law enforcement, most recently as inspector with the Oklahoma City police department, where I had the privilege of being the department's primary liaison to the Oklahoma County drug court team.

In my nearly two years of participation -- I'm sorry, two decades of participation in drug court teams, in training hundreds of courts nationally and internationally, I have found no other method as effective at reducing crime and saving valuable resources by ending the revolving door of those with substance use and reoccurring disorders, and entering and re-entering the criminal justice system.

I even use this model because I felt so strongly about it when I served as the chair

of the Department of Parole Board in the State of Oklahoma for two years.

In that capacity, I had the opportunity to train other board members on risk and need, and addressing all of those key issues that we were able to address through my training and experience in drug court, and based on that, we definitely saw a tremendous impact in offenders, as they were being released on parole through the State of Oklahoma, and we saw great improvements in that respect.

So, drug court reaches far beyond serving those that are in the traditional criminal justice system, preventing them from going to prison, but we can also use that model for those that are being released from prison and going back out in the community, looking at all of those key best practices and the standards that go along with it.

The United States is in the midst of an opioid epidemic. Americans from all ages,

areas, and socioeconomic backgrounds are being affected by the surge of opioid misuse. In fact, according to the Centers for Disease Control and Prevention, at least 91 Americans die each day from an opioid overdose, accounting for more than 60 percent of drug overdose deaths in the United States.

But it is hardly the first time our country has faced this epidemic. In the 1980s, crack cocaine was infecting the streets and cities across America, sparking policy makers nationwide to adopt polices viewed as tough on crime.

These policies coupled with the now-infamous war on drugs emphasized harsh punishment for any type of drug-related crime, but quite simply it did not work.

For more than 10 years, serving as a police officer on patrol in Oklahoma City, I tried to arrest our community out of the problem, and clearly, it was not working because in the

time it took me to arrest and complete a report, the offender had posted bond and was out getting -- engaging in that criminal activity again and engaging in drug use.

Nowhere in the country was there more -- was it more evident than Miami, Florida. Crack cocaine was king, and people falling victim to its rapid spread were finding themselves in and out of justice system, powerless to do little more than try to incarcerate its way out of public health crisis.

Fed up with the backlog of cases involving people with serious substance use disorder and over-crowded, over-spent jails, a group of professionals in the county justice system decided to come up with the solution.

In 1989, under the supervision of Judge Stanley Goldstein, Miami Dade opened the first program that would become known as drug court.

In sharp contrast to practice today,

emphasis is -- in this court was placed on providing the max -- not providing the maximum amount of jail time, but more of a focus on treatment and accountability for those individuals, which is something drug court provides, the structure is there, something that these individuals have never had for a large majority of their life.

So, in drug court, the drug -- the Judge, the prosecutor, defense attorney, law enforcement and probation officers work as a team, along with clinicians, case managers and treatment providers to ensure each program participant receives an individualized, evidence-based treatment plan.

In these new courts, participants were capable of overcoming their addiction and not seen as society outcasts, whose only place in the world was behind bars, and what we know today is that it is working.

Soon jurisdictions across the country

search of their own solutions to the growing drug crisis started adopting this experimental model in Miami. Courts from Rochester, New York to Kansas City, Missouri, to Portland, Oregon were finding drug court was not only saving lives, but saving thousands of taxpayer dollars, making it easier to sell to local and state governments.

My experience started in May of -- in March of 1998, in Oklahoma County when we started our first drug court program, and looking at the model that was established by the National Association of Drug Court Professionals at that time, we embraced that model.

We had statutes that helped us -- helped guide us through the process of getting equal access to all individuals that were eligible for the services.

As a result of that program and following our first set of graduates, we were able to put a number with the effect of the program as far as cost savings, and in an 18 month

period, we saved the Department of Corrections $13 million, a little bit over actually $13 million, looking at the sentences of those individuals that would have graduated from the drug court program, and this was highly impactful for our legislators and it showed that in our state, we really wanted to take a serious look at how we could improve those -- that footprint of drug courts across our state in Oklahoma.

Soon jurisdictions began to embrace this solution, and as the 1990s progressed court began -- courts began operating in more and more jurisdictions across the country. But even as the drug courts received authorization in the 1994 Crime Bill, sending the number of drug courts in the United States skyrocketing, the movement lacked a clearly defined model.

That changed in 1997, with the newly formed National Association of Drug Court Professionals, working with the Bureau of Justice Assistance published a document called

"Defining Drug Court, the 10 key components", known in the field now as the "10 key components".

This early publication would become the core framework of drug court -- of the drug court model, setting the stage for best practices and expansion of drop -- drug courts, to serve other populations.

This population would expand to include DWI offenders, communities of -- tribal communities, families, veterans and other populations across the United States.

As more communities turned to drug courts in the 21st century, to help reduce crime and lower rising criminal justice costs, the body of research continued to expand, making drug court the most researched intervention in the just -- in the justice system.

The first wave of research confirmed that drug courts effectively did reduce drug use and crime while saving dollars. We saw that, it was very evident in the State of Oklahoma.

This research has been turned to focusing on determining why courts work and what elements of the model are most critical to the success of the program.

We now know that the effectiveness of drug courts depends largely on the adherence to the 10 key components. Courts that ignore or even loosely adopt the components see lower graduation rates and higher recidivism, all resulting in lower cost savings.

Going beyond simply validating the broad principles of the 10 key components, the research gave them life, in cementing them in our field as standards for practice.

Armed with this research, NADCP recognized the need to provide drug courts with guidance on how to operationalize the components and ensure fidelity to the model.

Research means the subjectiveness of accepting someone in a drug court program, to more of a model of equity and inclusion across

populations in the drug court field.

We know now that drug court is most effective for those at highest risk for recidivism and the highest need of treatment for substance use and disorder. In the field we call that high risk/high need individuals. They are those that are hardest to address those issues, but would get the greatest return on the dollar when we do serve that population and make them a target.

Moreover, we know outcomes are further improved for participants if they complete 200 or more hours of drug treatment counseling, take advantage of medication assistance treatment when applicable, and have access to a wide range of complementary social services, including housing assistance, family counseling and educational services. We commonly call these wrap-around services.

If these services aren't available it is the equivalent of throwing the baby out with

the bath water if you will, because we may have gotten the baby clean, but there are still some other issues around them and their environment that they need to clean up and they need help and case management with.

So, this new model provides an opportunity through the best practice standards to help address those concerns.

Knowing these and other critical elements, NADCP developed the adult drug court bath -- best practice standards. The standards incorporate more than a quarter century of research, defining appropriate practices for drug courts across a spectrum of highly researched principles, including target populations, team roles, equity and inclusion evaluate -- and evaluations and others.

Since this -- their release, the effect of the standards on the drug court field has been profound. New drug courts are using the standards as the foundation for building a

successful program and existing courts are using them to adopt new policies and retool their programs. Already 22 states have either adopted NADCP's best practice standards or are incorporating them into their own standards.

Last year, the White House Office of National Drug Control Policy awarded NADCP with funding to aide states in implementing the standards in their jurisdictions.

Ten standards outlines in -- outlined in two volumes were carefully chosen based on research showing they unequivocally improve outcomes in drug court.

Of course, there are other essential practice that courts perform, designed to answer the unique needs of their communities not addressed by the standards.

The drug court field has always and will continue to follow the research. We also fully expect the standards will continue to evolve with time and further volumes will be

released, as new research continues to be validated regarding other essential practices.

The standards are applied to other models of treatment courts outside of adult drug courts. However, when applying these standards to other models such as DWI courts and veterans treatment court, consideration must be given to the population that is being served and what standards really apply to those, as far as the research is concerned to support those populations.

In conclusion, what started in Miami as a bold plan to reduce recidivism in 1999 -- 1989 is today, an international movement dedicated to a smarter and economic -- smarter economic and more effective approach to substance use and mental health disorders in the criminal justice system.

There are more than 3,000 treatment courts in the United States, covering every state and territory, serving a variety of populations,

including adults, juveniles, federal offenders, tribal communities, veterans and many others.

I am honored to testify before you today about this life-saving program that I truly do believe makes a difference in the lives of individuals, in the lives of communities and in the lives of families across America. Thank you for your time and I welcome your questions.

ACTING CHAIR PRYOR: Thank you, Ms. Price. Dr. Taxman. We have a traffic light system today.

DR. TAXMAN: I see.

ACTING CHAIR PRYOR: Green light, yellow and red, so, just to help let you know how much time you have.

DR. TAXMAN: Okay, thank you very much. So, my name is Faye Taxman. I'm a University Professor at George Mason University in Fairfax, Virginia. My area of expertise is in the area of sentencing and corrections, and I'm part of the Department of Criminology, Law

and Society, and I also run a research center called the Center for Advancing Correctional Excellence.

So, what I want to devote my time to today is around the concept of alternatives to incarceration and thinking about evidence-based practices, and I want to focus my attention because the terminology of alternatives to incarceration actually started in the late 80s, early 90s, to indicate something between probation and prison, because there was perspective that probation wasn't tough enough. It didn't really punish people, nor did it actually achieve objectives of changing behavior.

So, Norval Morris, who at that time was at the University of Chicago, and Michael Tonry, who is now a professor at the University of Minnesota, actually wrote a landmark book called Between Probation and Prison, that really talked about the need for more intermediate sanctions, not alternatives, because the concept

of alternatives is that basically we're looking at a secondary punishment that is in lieu of incarceration, instead of looking at a legitimate punishment.

So, what I'd like to make the point this morning is that really, what we have learned over the last 30 years is that we actually have access to legitimate punishment vehicles that can act -- be used to really identify, you know, a type of sentence that is more appropriate for an individual and to diminish the use of incarceration because what we know from the research literature is that actually incarceration is -- it actually contributes to more recidivism and in the research literature itself, Frank Cohen, Alex Vacarro, other scholars in the field of criminology have basically found it to be criminogenic, i.e., the schools of crime, and therefore, who we place into prison and how we use incarceration, it should be a great concern as I know it is to the Sentencing

Commission.

Now, you know, let's put it in context. You know, the United States is the -- basically has five percent of the world's population and yet, we incarcerate 25 percent of the world's people incarcerated.

That's an indicator that is not necessarily perceived as being positive. But it also suggests to us that maybe we should be thinking about how we use this resource of incarceration.

So, Acting Chairman Pryor, you indicated that there are high recidivism rates from people who go to prison.

What we don't know is what would be those recidivism rates if people were not incarcerated, and in fact, what the research literature would suggest to us is that we could actually reduce those recidivism rates considerably if we placed people into the more appropriate intermediate punishment for that

particular person.

Drug treatment courts, as Ms. Price has indicated, is one example of an appropriate punishment for a select type of a person.

But I think what's most important to us today is that we realize that the vehicles that -- you know, that we have relied upon as a society, incarceration, long prison sentences, actually have had counter-influences, in terms of citizenship and in terms of, you know, citizens and their citizenship in our society, as well as issues related to social injustice and we had a number of opportunities, including at the National Research Council a few years ago, who basically looked at the issues about the length of our sentences.

So, the question is what is the way forward? How should we be thinking about this in 2017, and this is where I would ask you to really look at what we've learned in the research over the last 40 years, in this particular area,

the movement of what is entitled what works, evidence-based practice, evidence important practice, there's a number of titles there.

But I think what the evidence-based practice, or I know what the evidence-based practice model offers to us is that we should, you know, think about punishments for individuals based upon trying to reduce the recidivism rates, and the best way to do that is to tailor the punishment based upon the risk that the individual offers to society, and the needs that the client has and those needs are those targets that we can actually, you know, respond to, in order to reduce the likelihood of recidivism.

So, in the evidence-based practice literature there is a list of needs, of which substance use disorders is on that list, and for substance abuse disorders, we actually have a number of very effective vehicles to, you know, to address the behaviors of an individual and help that person achieve recovery.

As Ms. Price indicated, drug treatment courts are on the top of that list, along with therapeutic communities, along with some models of probation supervision, particularly some models that the U.S. Administrative Office of the Courts subscribe to, as well as some of the effective treatment programs, like medically assisted treatment with cognitive behavior programming.

So, there is a list of different vehicles that we can use to really reduce the recidivism rates, improve the recovery and actually help people deal with those addiction disorders that drive the criminal behavior that brings them to the attention of the criminal justice system. That's a portion of the population.

There is also people who subscribe to anti-social cognitions and cultures, and therefore, we also have an assortment of treatment interventions for that particular

individual.

So, I see a little red light has gone on. So, I'm going to just make two concluding remarks.

First of all, I hope that the Commission really considers looking at the empirical literature and thinking about reducing the use of incarceration, particularly with the strides that the U.S. Administrative Office of the Courts has made in terms of adopting evidence-based supervision.

You know, I've had the pleasure of working with the U.S. Administrative Office of the Courts for about the last decade and they have embraced an instrument called PCRA that they developed and they use, and it is, I would say, first of all, it's one of the most fairly recent instruments, and they've done some good work in terms of identifying different types of offenders and what types of interventions would be best served for that topology.

That's how we're going to reduce that recidivism rate.

The second point that I want to make, and Ms. Price alluded to this, is program quality is a key, and we don't spend enough effort, we the -- our society, on really supporting the programs and services that are -- you know, that offenders participate in.

Program quality is one of the largest issues that reduces the recidivism rates, and yet that is something that we can really invest a lot of our time and energy, pretty cost-effectively, and it will have a greater yield to the communities where people live.

My team has developed some techniques of really trying to give people information about, you know, the quality of the programs that they have in their jurisdiction, so people can actually focus attention on trying to use the evidence-based treatment literature and integrate that into their particular programs and

I know that it might be slightly outside of the scope of the Commission to really look at program quality issues, but I think that, you know, in your role as the Commission, you could actually ask the Administrative Office of the Courts or others that people are -- communities that people are sentenced to -- to -- for Judges to pay attention to those issues.

Many Judges I know, including Judge Sorokin here, you know, in their work, in their communities have really worked with local programs to improve the quality of those programs and they see the great benefit that actually can occur.

So, Judges, as leaders in their communities, I think have a large role of really doing what drug treatment courts have done, in you know, getting, you know, justice actors as a civilian-type force to really improve the quality of services that are offered to people involved in the justice service -- system.

So, it's in our society's benefit, right? You cited the statistic about 70 percent, I think recidivism rates over an eight-year period of time, if I got it correct.

ACTING CHAIR PRYOR: Actually, the 76 percent recidivism rate was for the state --

DR. TAXMAN: Oh.

ACTING CHAIR PRYOR: -- contrasted with the more like 50 percent of the drug traffickers followed over an eight-year period in the federal system.

DR. TAXMAN: Okay, sorry.

ACTING CHAIR PRYOR: That's okay.

DR. TAXMAN: I'm used to hearing the BJS numbers of the --

ACTING CHAIR PRYOR: Yes, the 70-something percent.

DR. TAXMAN: Yes.

ACTING CHAIR PRYOR: Those are the BJS numbers.

DR. TAXMAN: So, but my point is, is

that, you know, as a society, we're not providing the effective services and punishments to really help change those behaviors, and we know that we do have a laundry list of, you know, toolkits that's available to do that, and I would just encourage the Commission to look at that, and to really think about how better to do, you know, more of a continuum of sanctioning than just really relying upon incarceration.

So, thank you very much.

ACTING CHAIR PRYOR: Thank you, Dr. Taxman. I would ask either one of you, do you have a sense of whether what you've referred to as alternatives or intermediate punishments -- whether the research shows that they work best with lower risk offenders more often seen in this -- in the state criminal justice systems, and how if at all, that contrasts with the federal offender population that we see, whether that is a higher risk group and whether those -- those kinds of programs have been shown with the kind

of offenders that we in federal court see?

DR. TAXMAN: So, the concept of low risk is basically that the person has a low likelihood of further engagement in the justice system and typically, it all depends upon on the instrument that one uses. But typically risk is different than needs.

So, you're -- you're typically focusing your attention on people who are low risk, but also low needs, and in the state systems, for the most part, those individuals, you know, are best served by the minimalistic interventions that we can offer, because on their own, they can be punished, you know, through community service, fines, you know, small punishments, and basically do fairly well without the state needing to actually intervene.

When you have a low risk person that has some needs, like let's say a substance use disorder or opioid disorder, then you want to really channel that person into a program dealing

with that need.

Typically, though most low risk people do not have a lot of needs, and we actually -- it's been about five years now. We did a study for the National Institute of Corrections for people who are coming out of federal prisons, who went to the federal re-entry centers and then went on to probation, and we used at that time, the instrument that the federal probation system used. It was called the RPI, and we used that to look at the percentage of people coming out of prison and what their risk level was, because at the time, the Federal Bureau of Prisons did not real -- did not have a risk instrument.

Surprisingly in the federal re-entry centers, somewhere between 30 to 40 percent of the individuals actually scored low risk on the Administrative Office of the Court's instrument and by the placing them in the federal re-entry centers, they actually ended up doing worse than the group of people who got released from federal

prison who didn't -- who were low risk, who did not go through the federal re-entry center.

So, what we generally learned is that, you know, if we give too much attention to people who are low risk, we're not going to really address the issues.

On the other hand, the moderate risk to high risk is where we should be focusing our attention for programs and services, and that way also, if we think about the scarce resources that states and the federal government have for treatment services, we can, you know, basically channel ourselves to focusing attention on those specific needs and using effective programs like drug treatment courts for people with serious substance use disorders.

I myself, I know the research literature, you know, fairly well and I think there are some, you know, there is a -- a debate going on in the research literature now about the high, moderate risk and who should go into drug

courts.

I personally think that, you know, given the success of drug courts, anyone who has a serious addiction disorder whether they're moderate risk or high risk should -- is best served either in the drug treatment court or some type of therapeutic community based, you know, from the research findings.

ACTING CHAIR PRYOR: How much does the type of risk matter versus what -- for example, you may be a high risk of re-offending, because you're an addict, right? But that's different than someone who is a high risk of recidivating with violence because they have a history of violence.

DR. TAXMAN: Right.

ACTING CHAIR PRYOR: What about that?

DR. TAXMAN: So, you know, so, we know much more about treating addiction disorders and the impact of programs reducing recidivism rates for addiction disorders than actually correction

and violence prevention.

It's an area of emerging research and there is a number of studies currently going on.

But essentially, by using cognitive behavioral therapies which have been demonstrated for almost 40 years to be the effective type of intervention for people involved in the justice system, you can actually cut the recidivism rate by a third to half.

You know, it all depends on the individual and the quality of the program. So, you can get those high reductions in recidivism rate if you have really high quality programs. Unfortunately, we don't have a lot of high quality programs. More likely than not, the effects of the meta-analysis are more in the smaller range of 15 to 20 percent, but that's still, you know, compared to the recidivism rates of people coming out of prison, remarkable reductions, and something to consider.

COMMISSIONER BARKOW: Can I ask you a

question about -- you noted in your testimony that the results haven't been the same for re-entry, and I was curious if either of you are familiar with the re-entry model, why they haven't been as successful or if you have any evidence of re-entry in courts that have worked well and what their features are.

I'm just trying to get a sense if there is research that shows using these as re-entry courts or intervening at that stage is helpful.

DR. TAXMAN: You want to get this?

MS. PRICE: I would -- I would state to the -- with respect to re-entry courts have taken on a different model, with regard to the drug court model and so, within that, they have to consider certain things.

For instance, in the federal system, looking at a -- a court as a re-entry model. What we -- what we've seen, although the research isn't -- isn't -- isn't complete on it, what we've

seen is that they do tend to do better because that structure is provided there and the accountability that goes along with supporting them through that system.

In the traditional drug court system, a couple of years ago, the Department of Justice and an RSTA grants, which are residential substance abuse treatment programs, which were the re-entry model, and what they saw in those models, before the research actually came out on drug courts was is that when you offered comprehensive wrap-around services for an individual, they did better, and particularly they did better when we were looking at the high risk/high need population.

That funding came out at a time when we were really dealing with a high occurrence of methamphetamine addiction, and so, there are a lot of needs for those individuals, and they fell in that high risk/high need category speaking with regard to if they went on traditional

probation, they were not going to be successful.

We did not look at the issue of violence because typically drug courts across the country, it was prohibited for them to be -- to have a violent history of a -- or a propensity toward violence.

So, what we know is, is that when you -- when you take a look at the individual as Dr. Taxman said, you really do have to look at those core issues and be able to have regardless of what the model is, you have to have those services and you have to have complete, comprehensive, evidence-based services for those individuals, in order for them to be successful. It has to speak to what their needs are, in order for that program to have an effect on them.

COMMISSIONER BARKOW: Do you need to have a judge be involved in that, or is that something that can just be done through probation?

So, I guess one of the questions is

how important is it to have judicial involvement with this versus the probation department leading the way on the wrap-around services and everything else?

MS. PRICE: I'll give you one stat that really speaks to that.

I am -- personally, I've seen the impact that a judge has on courts, and what the research says, through Dr. Doug Marlowe is that a judge spending three minutes talking with that individual about what's been going on with them, had a greater impact than any other interaction of team members.

All -- it's not to say that those other impacts or interactions were not impactful, but what it says is that when that person that has been through the criminal justice system, that has a significant history, has a positive interaction, where the judge knows what's going on with them, what their level of accountability is, what they've been doing in treatment and can

speak individually to that person, then it made a difference because there was a certain buy in. There was a certain level of respect that that individual began to develop for criminal justice that had never existed before.

So, just three minutes with each individual, the research says that it reduced recidivism and it increased cost savings for that particular court.

COMMISSIONER BREYER: I'd like to -- oh.

COMMISSIONER SMOOT: I just have a really quick question. I'm actually in favor of drug courts because I've put together a drug court in Maryland, as well as in the District of Columbia, and I do have a really pointed question with regard to recidivism.

So, have you done taking a person who is -- has gone through the courts and who has gone through the drug courts and people who have not?

What is the actual difference in recidivism rates? I haven't heard that.

MS. PRICE: So, we did have those numbers. I don't have them,

COMMISSIONER SMOOT: but that's going to be a really crucial

MS. PRICE: -- because our researcher was not able to make it, that has actually facilitated that research.

But I can get that information to each and every one of you. That's really simple, giving an email to you guys, with all of that information and we do have it and there is a covert comparison studies with similar populations that were charged with similar crimes, that looked at the traditional system and then those that went through the drug court system and looking at all of those outcomes in areas of treatment and involvement with different members of law enforcement doing it as members of the team, looking at who the components was, what

type of services they received and the interactions amongst those team members with that individual. So, we do have that data that can be available.

COMMISSIONER SMOOT: Just as follow up, I totally agree that background services are helpful. The issue is going to be how helpful, in order for people to continue them.

DR. TAXMAN: So, I would refer you to a meta-analysis that was completed by -- completed by -- I can provide you with a copy of it, O.J. Mitchell and David Wilson who is the chair of my department, and Doris MacKenzie at the Penn State University, which was completed in 2014, where they looked at the available drug treatment court literature and they compared synthesized the literature to look at the impact on recidivism and they essentially found approximately a 20 to 25 percent effect size, which is, you know, a small difference, but a substantial difference in terms of recidivism

rates, and that -- that piece of research which basically, the concept of the meta-analysis is to synthesize all the available studies, basically is used as, you know, the foundation for evidence-based practices.

COMMISSIONER BREYER: I'd like to ask -- I have a sense that judges, federal judges are of the opinion that they are actually operating a drug court by and large, because of the great volume of drug cases that we get.

So, I am interested in the distinction between the operation of a drug court at the outset versus of the operation of a drug court for people who have failed some type of court supervision, either through re-entry or a supervised release violation and so forth.

Do you -- have you -- does your drug court information, where you say look, we have a lower rate of recidivism, a higher rate of success in treating these people, does that distinguish between people who are coming into

the justice system before conviction and have an addiction problem versus those people who have been convicted, have served some type of time in custody and then come out, and then as we refer to them, basically a re-entry issue?

Do you distinguish between those two groups?

MS. PRICE: I think there are --

COMMISSIONER BREYER: As to drug court.

MS. PRICE: I think there may be a -- using the same word with different meanings, as far as re-entry is concerned.

What we consider re-entry is someone that's coming out of prison and they have a term to serve on probation and they're re-entering, as opposed to a failure.

We usually look at those as probation failures and we do take those individuals and follow them through the drug court program, which may be a little bit different in -- it -- when -

- we may be speaking to different terms than you are.

COMMISSIONER BREYER: Well, I'm probably -- I'm trying to figure out for a judge, to implement some of these programs, there could be consider -- to consider some of these programs, we're very structured, in terms of where we see the person, when we see the person, what remedies are available and what the procedure is.

Very, very, you know, it's all set out and it's been followed in a particular way, whether it's good or bad, it's fair, and I'm trying to figure if research evidence shows that look, if you take a person who has an addiction problem and treat that person a particular way, as you are urging for -- whatever words you want to call it, whether you want to call it alternative incarceration, whether you want to call it addressing those factors that govern behavior, cognitive and so forth.

I want to see whether we can distinguish between those people that we get initially that have gone through the -- perhaps they have records, but we're seeing them for new charges, versus those people who have been placed on supervised release or probation and have "failed", that is that they have committed a further violation of whatever the terms and conditions of supervised release and probation, and have -- do you have the statistics that sort of show that there is or there isn't some difference between those groups?

DR. TAXMAN: So, the meta-analysis that I referred to essentially, it does not include people who we -- who are released from prison. It actually looks at actually pre-adjudication versus adjudication and pre-adjudication are, you know, that basically, entered the drug court model before they're actually sentenced, as compared to those people who enter the drug court at sentencing, as a form

of sentencing.

That particular body of research found that the pre-adjudication reduces recidivism moreso than the adjudication-based drug treatment court.

But I do want to make -- I want to clarify, and I think the language does get really convoluted.

It -- so, when referring to drug treatment courts, we're actually, you know, if you use the standards that NADCP has promoted for the last 30-some-odd years, that is different than probation with treatment, and it's different than people being released --

COMMISSIONER BREYER: Right.

DR. TAXMAN: -- and coming back to, you know, and being placed in some sort of treatment program, and the difference is, is that the justice actors, judges, prosecutors, defense attorneys, case managers, probation officers and then the treatment providers really are a team

and that team works to reinforce a certain message to the client that, you know, they're being given this opportunity to participate in an intensive program. They're supporting them and supporting here means both emotional support, but also the recognition that the person is, you know, taking responsibility for the behavior through the participation in this program, and that type of support is, you know, essentially what is considered the glue of the drug treatment court model, because it sends a consistent message to the offender or the client, whatever terminology one wants to use, that they are interested in their recovery and also, they are interested in reduced recidivism and people are going to work together.

That's a different model than when you have a -- you know, a sentence that includes probation plus treatment, and I think it's really important to distinguish, you know, because that's where, you know, the question about is the

judge needed?

Well, the judge and all the actors are needed because they're sending a consistent message to the person and you know, the research literature, you know, suggests that that message be delivered by the broader range of justice actors, is the powerful glue that reinforces that commitment to change the recovery.

You know, Ms. Price indicated there is 3,000 drug courts and there is you know, about 100,000 people nationwide that participate in those drug courts.

We would be better as a society in my perspective, if we expanded the number of people who could participate in drug courts.

I'd like to answer the question about re-entering courts.

ACTING CHAIR PRYOR: Yeah, we're going to have to wrap this up fairly soon.

DR. TAXMAN: Okay, I'm sorry. But I think it's important.

So, the research on re-entry courts is really emerging and part of, I think the stickiness of that research, to be honest, is that if you don't know what the driving criminal behaviors are and you're not treating that through the re-entry courts, you're just trying to provide wrap-around services, then you're not really focusing attention on changing people.

With addictions it's clear, we're trying to actually deal with addiction disorder. But some of the other court models, you know, we're trying to solve sometimes some social problems, like homelessness and prostitution.

But I think with re-entry, if we focused our attention much more on some of the decision-making skills of clients and employment opportunities, you know, as a way of really helping people become stable citizens in their community, then we could have the same effect.

ACTING CHAIR PRYOR: Okay, thank you, both of you. We need to move onto our next panel.

Thank you for being here and sharing your testimony today.

DR. TAXMAN: Thank you.

ACTING CHAIR PRYOR: Our next panel, we will hear the perspective of three district court judges on alternatives to incarceration programs in the federal system.

First, we'll hear from Judge Dolly Gee. Judge Gee has served as a United States District Judge for the Central District of California since 2010.

She currently presides over the Conviction and Sentence Alternatives Program, everything in the federal government has an acronym. This one is CASA.

Before taking the bench, Judge Gee was in private practice in Los Angeles.

Judge Bruce Hendricks is a United States District Judge for the District of South Carolina, but before that she served as the United States Magistrate Judge in the District of

South Carolina.

Judge Hendricks presides over the Brick -- presided over the Bridge Program, the first drug court program in the District of South Carolina.

Finally, we'll hear from Judge Leo Sorokin. Judge Sorokin is a United States District Judge for the District of Massachusetts and previously served as a Magistrate Judge from 2005 to 2014 and presided over the Court Assisted Recovery Effort, C.A.R.E. court for the District of Massachusetts.

He was instrumental in the development of the Repair, Invest, Succeed and Emerge program, the RISE program, the District's pre-trial alternative court that is currently in its second year of a three-year pilot. Judge Gee.

JUDGE GEE: Good morning, Members of the Commission. It is my privilege to be here on behalf of the more than 20 very dedicated men and women of the Central District of California

who help to make the CASA program work.

I am not going to repeat the things that have already been submitted to you in writing, other than to say that the CASA program is different from many other so-called re-entry or diversion programs, in that it is a front-end, no entry program. And as its name suggests, it is a true conviction and sentencing alternative for a wide range of criminal defendants and criminal offenses, and it has the types of carrots and sticks that make this type of program work.

The very important carrot, of course, is the prospect of no prison time or no felony conviction. And just as importantly, the opportunity to change the trajectory in one's life, and the equally powerful sword of Damocles that dangles over every CASA participant's head is the prospect of failure and incarceration.

Today I'd like you to hear from some of our successful CASA graduates, in their own

words. But before we do that, I would like to respectfully make a suggestion, as to how the sentencing guidelines can become more relevant to programs like CASA, during your next amendment cycle.

Even a mere acknowledgment by the Commission that programs like CASA exist would help to institutionalize what has already become a new reality in our district, as well as many other districts that have chosen to follow a similar path.

Currently, the only place in which the sentencing guidelines have a role in a CASA participant's sentence is in the calculation inserted in the initial plea agreement that is entered into between the parties and at the time of an unsuccessful termination from the CASA program.

At that time, the defendant is returned to the traditional sentencing regime, and is subject to whatever penalties that the

sentencing judge may deem appropriate, which includes potentially a sentence within the sentencing guidelines.

For a successful track to CASA graduate however, the probationary sentence that CASA judges impose pursuant to the parties binding plea agreement, is recorded in a Statement of Reasons invariably as a variance.

In my view, the guidelines should include language that recognizes programs like ours at the front end.

For example, a logical place where the guidelines could recognize such programs is at Section 5(b)1.l, where a statement could be inserted that in addition to those offenses falling within Zones A and B, which may be appropriate for a probationary sentence, that a probationary sentence could also be imposed pursuant to a court-authorized diversion program that provides intensive supervision.

Such a small change to the guidelines

would signal a seismic shift in our criminal justice system's attitude toward diversion programs. It would recognize the success of these programs and embrace rather than treat them as outliers in the system.

This in turn could encourage more widespread adoption of such programs across the country.

At this time, I would like to conclude my remarks by introducing you to some of our successful CASA graduates, who really are the reason why we do all of this.

I wish I could have brought them here in person to meet you, but because I could not, I must simply read a few excerpts of some of the letters that they have written to me and spoken in their CASA graduation speeches.

The first that I would like to introduce to you is Mikayel Badalion who is a CASA graduate from 2014. He pled guilty to bank fraud. He had a criminal history category of

one, and after he successfully graduated from CASA, his felony conviction was dismissed and he was ordered to pay restitution.

This is what he said at his graduation in part.

"When a firefighter runs into a burning building, it's nothing short of heroic. When a police officer runs into the line of fire, it's nothing short of heroic.

"Likewise, when a group of people realized that our criminal justice system is failing and our prison system is failing, and they come together to develop a program, to try to put people back on the right track and save their lives, it is nothing short of heroic.

"Ladies and gentlemen, the CASA program is not just a conviction and sentencing alternative. It's a second chance at life, and for that, we are all forever indebted to the program, especially myself.

"I know that my dreams of one day

becoming an attorney would not have been possible if it not been for the CASA program, and for that, I am forever grateful. But it's not only our lives that the CASA program has touched and will touch. It's like a ripple in the water, and the effects of the CASA program will be felt throughout time."

Every client that I'll ever help and every client that will ever thank me, will in turn, be thanking the CASA program, because without it, none of that would have been possible.

In 2016, Mr. Badalion became a licensed attorney and he will be speaking at the 9th Circuit Judicial Conference in San Francisco this summer about re-entry programs and mass incarceration.

COMMISSIONER BREYER: Judge Gee, let me just interrupt you. I know you have other things that you want to discuss -- other stories, but I want to get to some testimony here that I'm

particularly interested in.

First of all, in this program, we have a similar program in the Northern District. Not identical, but somewhat similar.

Do you have the consent of the United States Attorney in the designation of any of these people to participate in the CASA program? Is that a requirement or is it a practice?

JUDGE GEE: Oh, it is absolutely essential. The entire CASA program concept is based around a team approach, and the team consists of a representative from the United States Attorney's Office, from the Federal Public Defender's Office, from the pre-trial services, from the court, and the people who participate in CASA are vetted by the team, and of course, no participant can actually come to the CASA program unless the U.S. Attorney's Office has approved that person's participation.

COMMISSIONER BREYER: So, then I would assume that if an individual is subject to

a mandatory minimum, that person would not be considered for eligibility in the CASA program, is that --

JUDGE GEE: Well, theoretically, someone who is subject to a mandatory minimum could actually become eligible for the CASA program if the U.S. Attorney's Office chooses to charge that person differently.

So, there are many people who are higher-level participants, for example, in a drug trafficking operation, who are subject to mandatory minimum who would probably never be considered eligible for CASA.

COMMISSIONER BREYER: But those people, for example, in the conspiracy in -- and their role was one of a courier, where legally they may be responsible for amounts that might dictate or implicate the mandatory minimum, would they be considered?

JUDGE GEE: They could be considered again, if the U.S. Attorney's Office is willing

to charge them differently, and sometimes that happens. They would have a superseding indictment that will include a lesser charge than what they were originally charged with and therefore, not be subject to a mandatory minimum.

COMMISSIONER REEVES: How are all of these programs different than diversion that's available to all the federal courts --

JUDGE GEE: I think that --

COMMISSIONER REEVES: -- where we don't prosecute or don't handle the case for a year, the person's allowed then to go through treatment, but is working with the probation office, directly with the probation office that structures the program?

JUDGE GEE: I think that's a very important question because we throw these terms around and we think that we all know what we're talking about.

But in fact, there are very different distinctions between a lot of these programs.

In the past, a pure diversion program, which incidentally in our district, is not favored by the U.S. Attorney's Office, is one where someone is simply diverted out of the system and does not receive a sentence and does not go through any intensive supervision.

They simply are allowed to conduct their affairs for a year or so, and if they don't commit another offense, they can then perhaps have their felony dismissed or whatever.

The CASA program is an intense supervision program and it's favored by the U.S. Attorney's Office precisely for that reason.

COMMISSIONER REEVES: But the very --

JUDGE GEE: That is the --

COMMISSIONER REEVES: I apologize for interrupting. But can't diversion be the same way? Can it be set up the same way? It is in my district.

JUDGE GEE: Yes, it is. We call it diversion program with intensive supervision,

which is distinct from a diversion program that has no supervision.

So, there are different types of programs in that regard.

COMMISSIONER REEVES: Thank you.

COMMISSIONER BREYER: So, the difference is that in the CASA program, if a person is not successful in the CASA program, well, first off, the person is successful, they may still be convicted. Isn't that correct?

JUDGE GEE: Well, if they are successful in their -- what we call track two, they are --

COMMISSIONER BREYER: Right.

JUDGE GEE: -- convicted and receive a probationary sentence.

COMMISSIONER BREYER: So, they would -- even if they're successful, they may very well --

JUDGE GEE: They would receive --

COMMISSIONER BREYER: They may

receive a particular type of sentence, but it wouldn't be one without a conviction.

JUDGE GEE: That's correct. It's a binding plea agreement that calls for a probationary sentence in advance.

COMMISSIONER BREYER: And if they fail, they then are prosecuted in the normal --

JUDGE GEE: If they fail --

COMMISSIONER BREYER: -- course of --

JUDGE GEE: -- they would return back to the normal adversarial proceeding, where they would be sentenced pursuant to the guidelines under the 3553 factors.

COMMISSIONER BREYER: So, in a sense, the advantage is that you don't go through trial with that person, because that person has essentially pled guilty, and the sentencing has been deferred as the state from a pure diversion program, which they never even enter a plea of guilty.

JUDGE GEE: Well, not only that, but

they actually go through a year or sometimes two, of intensive supervision by a team, which includes a whole host of services and exercises that are intended to change that person's attitude and to prevent them from recidivating.

I see my red light is on so --

COMMISSIONER BREYER: I'm responsible.

JUDGE GEE: -- so, I will pass the microphone to Judge Hendricks.

JUDGE HENDRICKS: Thank you. Thank you to the Commission for having me here today. It's an honor to appear with my colleagues.

I want to start by emphasizing that I am here in a representative capacity. I've been tasked with facilitating our drug court in South Carolina, but I'm representing all the stakeholders there that make our drug court work and function. It's not a lone ranger enterprise in South Carolina, and even though we're one of the older federal front-end programs, I represent

so many more state and federal programs and we stand on the shoulder of their efforts.

My testimony today is simply an account of our experience and an approximation of our best practices.

Running a federal drug court is always one part legal and one part science fair project. It's glue and popsicle sticks.

We believe Section 3142 gives federal judges the ability to tailor these kinds of programs, but that doesn't mean that in South Carolina, we've figured out all the answers or that all aspects of this work fit cleanly within the existing statutory guidelines that exist.

So, today, I'm going to do my best to share our experience in drug court in the federal system, and as some of you know, the best way to understand it is really to see it.

So, I'm going to reciprocate your hospitality to ask you here today and invite you down to Charleston, South Carolina. Judge Breyer

can attest that we take all our hospitality very seriously down there.

The Criminal Law Committee has come to visit. I'm just saying. It would be an interesting experience and we'd welcome you to come.

Let me just say a couple of quick things, and then I'll answer any questions you might have.

South Carolina sought to create an alternative program to meet a need. That need was that the district judges in our district felt that we had inadequate tools at our disposal, when sentencing a particular category of cases, and at this point, over-incarceration is -- is an indisputable problem in the United States.

Front-end pre-trial drug courts are just one way of addressing a small part of that progress -- problem, but they're certainly not the only way of addressing it, and certainly not a solution to the problem writ large on a national

level.

In essence, the Bridge program in South Carolina, which is not an acronym. It's meant to reflect the Bridge to Sobriety.

But the Bridge program was our effort in South Carolina to be forward-thinking in our response to a perceived need for more sentencing options in the case of low level, non-violent drug offenders whose criminal conduct arises from their addiction, the nexus between the addiction and the offense that they're charged with must be established in order for them to be admitted into our program.

So, as laid out in our written remarks, our key purposes were three-fold.

To provide the alternative tools to the district judges for this class of cases, to ensure public safety and to achieve these first two goals with an eye towards responsibility.

In developing the program, we observed as many federal and state drug court programs as

we reasonably, and we openly and unabashedly solicited advice and materials that were way more well-versed in the field than ourselves.

We had a great opportunity to work with a state drug court judge in Greenville, South Carolina, Judge Chuck Simmons who was the past chairman of the National Association of Drug Court Professionals, and he runs a program there in Greenville. He's run it for 20 yearsvery successfully.

We've built the Bridge policies and procedures on the NADCP adult drug court best practice standards and the National Drug Court Institute 10 key components of the drug court, and we employ evidence-based practices embodied in those guiding documents.

One common question that we've seen is whether these courts are really appropriate for the federal system. In our view and experience is that the social science underlying the drug court program is not specific to a particular

court system, but it's really linked to human behavior and psychology generally, and the attributes of drug court programming are not system dependent, but rather human nature dependent.

We have designed the Bridge program to maintain flexibility with regard to the stage of the judicial proceedings that we can accommodate. Most of our participants are pre-trial. It's primarily a front-end program, but we can accommodate post-trial participants and a hybrid of the two, if necessary.

But the key thing, and I believe we mentioned it once is the program is conceived out of and run through the authority vested in the judiciary by Section 3142 of Title 18, and Section 3142 shows that federal judges really are already regulating the defendant's lives in the ways contemplated by drug court, that drug courts simply enforce the intensive treatment and supervision as provided by 3142, through regular

judicial accountability, and that's key, and I think you've heard some other testimony here this morning on where the role of the judge and the interaction with the judge on a regular basis, just makes for more powerful supervisory authority and it works.

ACTING CHAIR PRYOR: How many offenders are we talking about in a year who go through this program?

JUDGE HENDRICKS: Well, we've had 103 participants and between, we're running it in four divisions in South Carolina, Charleston, Columbia, Greenville and Florence. We've got approximately --

ACTING CHAIR PRYOR: That's 103 --

JUDGE HENDRICKS: -- 30 people in the program right now. So, every year, you know, probably in terms of graduation and completion, I would say more like 20 --

ACTING CHAIR PRYOR: Twenty a year?

JUDGE HENDRICKS: Yeah, on a state-

wide basis.

ACTING CHAIR PRYOR: On a state-wide basis, and how does that contrast with the state, like the program you had seen in Greenville, the state program?

JUDGE HENDRICKS: In terms of the numbers that run through it?

ACTING CHAIR PRYOR: Yeah.

JUDGE HENDRICKS: Much fewer. Probably half.

ACTING CHAIR PRYOR: State-wide versus what is in one -- one area of a state in a state program?

JUDGE HENDRICKS: Exactly.

ACTING CHAIR PRYOR: Okay.

JUDGE HENDRICKS: Yes, sir.

COMMISSIONER BREYER: Do you do some sort of risk assessment in determining who is going to be put in this program?

JUDGE HENDRICKS: Yes, and the U.S. probation office uses their assessment practices,

and our eligibility criteria really is stringent and it marries well with what probation is already doing, in terms of we study the criminal history. We really drill down on the criminal history and in -- mainly, they can't be violent or have any kind of pattern of dangerous activity.

But we don't just -- if there is a criminal history that appears, initially problematic, we don't just rest on that. We actually study it and look at the incident reports and so forth, and drill down on it, so that we can try to be as inclusive as possible with as many defendants and offenders as possible.

COMMISSIONER BREYER: Do you have buy-in from the U.S. Attorney?

JUDGE HENDRICKS: We do.

COMMISSIONER BREYER: All the offenders are drug offenders?

JUDGE HENDRICKS: No.

COMMISSIONER BREYER: No?

JUDGE HENDRICKS: Not necessarily. They can be fraud, counterfeiting. We've seen all manner, not necessarily drug offenders. But we do --

ACTING CHAIR PRYOR: Are they maybe less like to be drug offenders than say, other offenses?

JUDGE HENDRICKS: What's that now?

ACTING CHAIR PRYOR: Are they in fact, maybe then less likely to be drug offenders than say other kinds of offenders?

JUDGE HENDRICKS: No, I think that the property offenders -- there is really more property offenders than you realize in federal court, and the property offenders really tend to -- a number of them have addiction problems, and then the low-level drug offenders, as well.

But the key is, is to make sure that there is -- that we can clinically diagnosis and establish the nexus between the offense and the

addiction.

COMMISSIONER REEVES: Can I ask you a hypothetical?

JUDGE HENDRICKS: Um-hum.

COMMISSIONER REEVES: Let's say you have a low-level drug dealer who is an addict, heroin dealer, death results, is the person eligible for the program?

JUDGE HENDRICKS: Yes. I have such an offender in our program in Charleston --

COMMISSIONER REEVES: What do you say to the families?

JUDGE HENDRICKS: Well, the family actually endorsed and the father of the victim came and endorsed the admission of this young college-aged woman who was using heroin with the person that died. They were using the same heroin, and heroin is -- you know is so very --

COMMISSIONER REEVES: What do you say to the families that object to the person --

JUDGE HENDRICKS: That did not happen

in this particular -- on this one occasion. Hypothetically?

COMMISSIONER REEVES: Right.

JUDGE HENDRICKS: Hypothetically, I think that absolutely --

COMMISSIONER REEVES: Does the victim have a voice?

JUDGE HENDRICKS: We take that into consideration, of course, the victim would.

In this one case that we've had, the victim actually was a huge -- actually came to court and asked that the person be admitted.

COMMISSIONER REEVES: Okay.

JUDGE HENDRICKS: And she is very close to graduating now. She's a young college-aged woman and suffered some post-traumatic stress disorder as a result of the tragedy that occurred with the use of heroin and as you all probably heard by now, I don't know whether this heroin was laced with fentanyl, but there are some really dangerous misuses of opioids and

heroin going on.

COMMISSIONER BARKOW: Can I just ask any of you at this point, but I know on the preview, do any of you have control groups where you're trying to match up people who would otherwise be eligible for your program but aren't in it, to try to track the more real matched comparison group, someone in your program versus someone not, to see recidivism outcomes and --

JUDGE SOROKIN: Scientific random selected control group, like you'd have in an FDA double blind study?

COMMISSIONER BARKOW: Well, I don't know if it has to be that but the --

JUDGE SOROKIN: I know that the idea --

COMMISSIONER BARKOW: State drug courts and tried to figure out -- I was thinking either a matched population or some kind of study that you could say because when you say it works, I guess I'm just trying to get a handle on works,

as compared to --

JUDGE SOROKIN: To what?

COMMISSIONER BARKOW: Well, this kind of goes back to as compared to what question.

JUDGE GEE: We are --

JUDGE SOROKIN: Go ahead.

JUDGE GEE: We are in the middle of being evaluated by the Federal Judicial Center in an effort to determine a control group that we can compare our results to.

So, we don't have the results of that yet. We are expecting to hopefully conclude that study this year.

JUDGE SOROKIN: We did a study in 2009 -- in 2009, and we didn't have -- the reason I -- I don't mean to be facetious but it's a serious question about an FDA double blind study, and NIH has done a lot of research about effectiveness of drug courts, in addition to what the National Drug Court Institute is doing.

They're actually coming to judicial

conferences and you could invite them, I think. I'm sure they'd be happy to speak with you.

But they advocate the drug court model because one of the things they said -- they basically said, it's my understanding, their research shows that the criminal justice system is very poor at enforcing sobriety -- I'm sorry, is very good at enforcing sobriety, but only while enforcing metrics, but it fails once you get out of prison because then people relapse.

But the treatment is actually incredibly effective according to the -- not incredibly effective, it's effective, and it -- it's about as effective as it is with most other chronic long-term diseases, but the problem with drug treatment is people leave treatment.

What the criminal justice system can do is get people to stay in treatment, and so, we did a study in 2009 at our -- and I think you need to be careful about the word re-entry, it's a post-sentencing -- it's a re-entry court, but

there are two kinds of courts, drug re-entry, drug courts and non-re-entry courts that don't deal with people with substance abuse problems and there is a difference.

So, with ours, the one we did a study on was all re-entry drug court, and that study -- and I can -- I didn't submit to you, because it's not about a front-end program, but I can send it to you, concluded in a general way that we did better than a -- what we did -- what the researcher did was, we pulled data from people who were similarly situated on probation cases, so they weren't in the program, and looked at those people and what happened to them in terms of the date accomplished, the equivalent marker of graduation, the kinds of things that they require to graduate in a drug court, what did they do in terms of employment and we did better on those kinds of things. I'm happy to send you a copy of the study.

The problem with some of those studies

is, of course, the numbers in any given program are relatively small, and so, you need to look at meta-data or larger --

ACTING CHAIR PRYOR: Well, Judge Sorokin, do you want to go ahead with whatever prepared remarks that are --

JUDGE SOROKIN: Sure, I -- so, I'm not going to repeat what I submitted in writing to all of you. I just have a couple of different points that I wanted to make.

I think that Judge Gee's suggestion, which I just heard for the first time here, about the amendment to the guidelines, in terms of consideration a probationary sentence if you've completed the program, is a brilliant idea, both because it folds these kinds of programs within the guidelines, which I think do give a language to talk about and a frame work, and it begins the conversation that you could imagine, that that guideline would begin, which is then what are the appropriate programs and what are standards and

how to do it, because if you have children and your child broke their arm, you would bring them to the emergency room and expect the doctor to set the arm, and if it worked out badly, you wouldn't draw the conclusion that doctors don't know how to set broken arms.

You'd draw the conclusion that that doctor at that hospital probably didn't do it right, or there was a more complicated problem.

So, I think to some extent, you have that. That's what Judge -- Faye Taxman was talking about, in terms of quality programs.

You could -- the fact that there's a program that doesn't work, doesn't mean that the concepts don't work. It means maybe, but it might also mean maybe that it's just not being done right.

So, I endorse that idea. I think it's a great idea and I urge you to consider it.

With respect to Judge Reeves' question about diversion, I think that there is two other

differences then there. We have what you'd describe, in our district too, it's the -- not too favored by our U.S. Attorney's Office and it's mostly used for letter carriers who may have had a drug problem and they go to some level of supervision on probation.

But our program, on the front-end, I think there's two differences. One is, in our program, you have to plead guilty and then we don't make any promises to people except to promise that it wouldn't matter if we made any because we'd be required to honor it, which is to consider all the relevant facts at sentencing.

So, we make the promise -- you plead guilty, we'll consider the good and the bad at sentencing. Now, the practical reality is if you do well, given how we're picking them, you're likely not to go to jail.

But we do have, with respect to -- we've never had a death-resulting case come into our front-end program. I think the answer to one

of the -- and we would certainly consider what the victim's family felt.

But I think there is two answers to the question. One is the U.S. Attorney's Office is their formal voice, and in our program, we operate essentially on a consensus basis, not as a legal matter, but as an operational matter, much as we have done for years with our drug court.

So, if there is -- we have never accepted anybody with the U.S. Attorney's Office objecting to it. So, if they said no, we won't -- we're going to prosecute the person for the -- I think it's 20 years, right, 20 or mandatory, then we wouldn't take them.

So, but the other piece -- and this is something I wanted to emphasize in our program. We have an -- and I think it speaks to just what you're asking about, in part.

We have a restorative justice component. If you want to be in our front-end

program, which is a voluntary program, you have to participate in our restorative justice program, and there's three parts.

First part is our -- our short meeting with our restorative-justice-trained probation officer, who just gives you an idea of what the restoring justice part is about.

The second is a two-day workshop that you have to -- all day, two days, so you have to participate.

So, it will be about six of the offenders. It will be the probation officer or two. It will be some community services representatives and we have a number of mothers whose sons have been killed in the drug trade, who participate in this, and sit in the two day conference with these people, and it's been an incredibly positive experience because one of our goals is, we want the defendants to appreciate the harm that they caused on an emotional or human level, not in this abstract mathematical sense,

and they do.

In fact, there's -- we just had someone who -- who was a drug offender and drug just -- convicted of drug distribution. He participated, and your question made me think of it because what he did, the third part of the restorative justice process is we encourage, we don't require, but we encourage the defendants in our front-end program to do an individual restorative justice project, where they make amends.

So, they've appreciated the harm that they've caused, and now, we want them to do something to make amends, for what they've done, and because that's essentially they put the world out of order in some way, by committing the crime.

So, what he did is, he wanted to meet with the mother of a friend of his who had died of a drug overdose. He had never been charged in any way with culpable responsibility for that, but he felt responsible for encouraging and

participating in that young man's drug life and addiction.

So, the mother was willing and the two of them had a meeting where he, you know, asked for her forgiveness. He confessed, in his view, his personal responsibility for her son's death. She afterwards -- they came up with a plan of things for him to do, which he is now working on, to sort of further -- sort of try to take something positive out of what happened to her son's life.

But she told our -- separately, afterwards, our probation office that she was very pleased both -- it was a hard experience for her, but she thought it was a very moving and worthwhile one. She was very happy to have had the opportunity to do it for herself, and that she thought it was a positive thing for him.

So, that isn't for every family, but it is an opportunity that if we don't provide it, that we're going to be denying it to some

families, and so, I think it's an important consideration.

This isn't in my written remarks, but we are -- there are some similar restorative justice accountability programs that are on a voluntary basis, offered in our state prison in Massachusetts, and we now -- as a court -- they've approved a pilot to offer an eight week introductory, voluntary, no, nothing like it's not even -- it's just a thing that we're going to offer in the pre-trial detention facility, because it's our belief, from this experience, that the Bureau of Prisons should be doing -- providing more opportunity for these kinds of programs and that hits a quick other couple remarks, that I wanted to hit on -- that I want to make.

One is I think that -- I suggest that the Commission --

COMMISSIONER BREYER: Can I just --

JUDGE SOROKIN: Yes.

COMMISSIONER BREYER: -- interrupt for a second? You said the Bureau of Prisons. But these are -- these are your pre-trial --

JUDGE SOROKIN: Yes.

COMMISSIONER BREYER: -- this is --

JUDGE SOROKIN: Yes.

COMMISSIONER BREYER: -- this is all within the --

JUDGE SOROKIN: All within the -- so, we're not doing -- all the things that I described so far aren't with the Bureau of Prisons. They're all pre-trial or post-unsupervised release.

But I do think that the Bureau of Prisons should offer two kinds of programming.

I think they should offer restorative -- a kind of accountability/restorative justice program, which has been pioneered and it's offered in our state prisons, it's offered in the California state prisons.

There's a similar program in the Texas

Department of Corrections. It's run actually by a man whose wife -- not his wife, his sister was murdered and for that, 25,000 people have gone through that program, and so, I think they should offer that.

But I think the Commission -- I was looking at the organic statute, and the Commission itself is charged with -- in Section 994, I think it's (g), to make recommendations regarding the nature of prisons facilities and services, and I think that that's -- one of the things that sentencing as part of, I think, your writ, and I think that one of the things that happens at sentencing, is we know more about the person than at any other time, and one thing that we have done in the District of Massachusetts if we have pre-qualified people for the RDAP program.

So, one could say we're just doing the BOP's work, but it's actually a very sensible thing, because what's happened is, now, when a

defense attorney says well, I want my client to go into the RDAP program, we have hard information, either they're appropriate or they're not.

Our hit rate is something like 99 percent because our probation officers are trained by BOP. They like it. It does -- so, it gives us better information on that recommendation, but it does something else, which is really significant.

We have persuaded and worked with the Bureau of Prisons to create this pilot program. Now, what happens, if you're in the District of Massachusetts, you have a drug addiction, you go to prison, because that's what's the appropriate sentence and if you -- you do the RDAP program, when you come out, ordinarily you go to the residential re-entry center.

That's not a treatment facility and the direct -- lot of the people in the RDAP -- run the RDAP program have told me they wouldn't

send a RDAP graduate to a general population unit in the BOP facility, because it would undermine the benefits of the therapeutic entity that RDAP is.

But the residential re-entry center is a general population facility because everybody comes out to it.

So, what the BOP agreed to do is, is we're sending those RDAP graduates who are in this recommended by the Judge, this pilot, to a drug treatment program in the community that mirrors the -- but it's a fair -- it's a treatment program. Everybody has the same responsibilities. Probation supervises them, so Bureau of Prisons imposes this same kind of restrictions.

COMMISSIONER BREYER: So, it's a specialized type of re-entry.

JUDGE SOROKIN: Exactly.

COMMISSIONER BREYER: Residential --

JUDGE SOROKIN: Exactly, and similar

price. Daily cost, and so, but what it illustrates here I think is that instead of the Bureau of Prisons being a silo over here, and sentencing silo over here and the supervised release is a silo over there, the three -- we need to talk to each other and communicate and coordinate and so, we've created -- it wasn't easy but and it took a long time, but we've created this coordinated path and I think there is a second group of offenders, this gets back to your question, Judge Breyer, with respect to are federal offenders different.

There is a second group of offenders who are sort of the re-entry court offenders, who don't have a drug problem, and those offenders, truth be told, we see many of them, they're typically in drug and gun cases.

They've typically dropped out of school at an early age. They typical sometimes they smoke a lot of marijuana, but they don't otherwise have a drug problem. They rarely

worked at all. Sometimes they have a little bit of work history and those people are -- have a high rate of recidivism.

They score high on the old RPI. They score high on the various needs categories under PCRA and what they need is a treatment program. They need to -- they need -- they need accountability, responsibility. They needs skills and work ethics. They need to be -- they need expectations.

One of the things judges imposes in this program is expectations. Casey Rodgers -- Judge Rodgers, those of you who know her, has a program in Pensacola that's focused with this population with cognitive behavioral therapy. My suggest -- this may be beyond my scope of the Commission.

But coming back to sort of encouraging programs under the organic statute, those offenders need sort of in-prison programs. They're not eligible for RDAP.

ACTING CHAIR PRYOR: What are your numbers like? How many --

JUDGE SOROKIN: Some of them are like --

ACTING CHAIR PRYOR: What are you talking about?

JUDGE SOROKIN: We're talking about I think 20 like re-entry drug court is up to 20. Our front-end program, it had -- in a moment, 46 people have applied since we began in August 2015, 19 became participants.

We terminated two, which means that they weren't for one reason or another working out. Six have graduated, completed, graduated and been sentenced and 11 are involved.

So, the numbers aren't large, but I think that goes to the second point, which is that there's not one type of federal offender. There's a range of people. There's low-risk. There's high-risk. There's drug addicts and what we've identified is a group of people who we think

we can do better with at a -- and -- and I would encourage the court to think about it.

One last suggestion, the red light is on, but I think it's an important one, which I suggest you consider amended expanding 5K, the 5K departure, not touching and changing in any way, what exists now, with respect to government-recommended departure for people who have substantially assisted the prosecution of someone else.

But I suggest we expand it to allow the government to file such a motion when a defendant, while he did not provide substantial assistance in the prosecution of someone else, provided substantial assistance in identifying and helping people who are in the community, who are addicted to drugs seeking engaging treatment, and the reason I propose that now, in light of the opiate crisis is because there are defendants who are drug offenders who have that information, so, talking any Title 3 or other surveillance

information that the government has acquired and those people are at great risk of harming the public and harming themselves, especially in a heroin kind of case and they could die, and there are some programs, at least in Massachusetts, there's a local police department that now couples their drug investigations to identify users and try to drive them into treatment.

Recently, I raised this once, just at sentencing and they were able to reach out and had the -- both the detective reaching out to some of the people they identified, and I think that it's information that's available, it's sentencing significant because if a defendant did that, it bears on his acceptance of responsibility and the way that he's made -- it's a drug dealer. He's making amends for what he did, if he helps a -- someone who he sold drugs to go into treatment.

So, I urge you to think about it. I don't think it tips any of the bounds of

authorities, because it would be vested in the hands of the government to make the motion or not.

I know it's not provided for you in your organic section, but the organic section doesn't say that's the only thing. It just says you shouldn't or must include that. So, I think that --

COMMISSIONER BARKOW: Is this for treatment, not prosecution?

JUDGE SOROKIN: Well, I think it's -- well, if they prosecuted the person, then I think it would fall within the first part, and you wouldn't necessarily need it, and I think that you could read it to encompass both prosecution in the sense of like a diversion or disposition in a state drug court that had a pre-adjudication or just for some of treatment program.

COMMISSIONER WROBLEWSKI: First of all, thank you all for being here and for sharing the experiences that you've had.

I just want to -- I want to focus on one thing that we heard from the first panel and that's the importance of program quality and support.

I've been going to Criminal Law Committee meetings for many, many years and my impression is that the general program quality and support embodied in our probation system and our probation officers is exceptional, especially compared to the state system.

So, what I'm having trouble with really understanding is the -- these are niche programs that you're describing, that have involved relatively few people compared to the docket that we have as a whole, which is 60,000 or 70,000 people.

What is it that makes these particular people, do you think, particularly amenable to some sort of special treatment as opposed to the standard program of quality support that we have for our probation --

JUDGE SOROKIN: I think that was -- I agree with you that in general, the probation office has -- does a very good job, has substantial resources, at least compared what I see in the state system.

I think one thing that these specialized programs offer that probation can't offer that we haven't talked about is essential.

So, at least in -- when you have the ability -- a judge can put somebody in prison on the spot, maybe just for a day, and I will tell you that when I started out in and started our re-entry drug court, I couldn't believe that anybody with any of the people that we were seeing who had all served their prison sentences, many of them long prison sentences, that they would care about a day in the marshal's lock up or an overnight at the county detention center that we use, but let me tell you, they do.

It is a very powerful sanction, they -- and it some ways it may be more powerful, I'm

not sure, but it might be more powerful with that category of defendants than someone who has never been to prison before because for them, it's a reminder of where they've been, and it is a powerful punishment and it had -- doesn't always work.

I'm not going to sit here and say that every time we sent someone to custody they took off like an airplane. But it was very effective. It's very powerful and one of the things that happens in the court is, you can do that. It's like, no, you don't -- it's early intervention and the probation officers, and it depends on the history, they might be able to, but the early interventions work is not as swift and there is a lot of research that shows you can change behavior by intervening as close in time.

So, that's one difference. So, I'm not sure that's about the people, but that's about something you can do in the courtroom, that a judge can do, that the probation officer can't

do, and that's very different.

JUDGE GEE: I would agree with that. I think that studies show that if there is immediate response to behavior that is a non-compliant, it is much more effective than waiting for whatever time it takes for a probation officer to petition the court to have that person brought in and face the court in the normal course.

We meet with our participants weekly and so, on a weekly basis we know what it is that they're doing and we can respond immediately to any kinds of non-compliance.

The other thing that I think is very important if that the people that we deal with form a bond with us. The team approach is very important because a lot of the people who participate have never had this type of structure before, and not withstanding that the probation and pre-trial services agencies do excellent work, they don't have the resources to do the

kind of intensive supervision that we provide, and I think that is what makes the difference.

We have had 137 graduates from our program.

ACTING CHAIR PRYOR: Over what period?

JUDGE GEE: Five years.

ACTING CHAIR PRYOR: Five years?

JUDGE GEE: So, we're averaging about 25 or so graduates per year.

COMMISSIONER BARKOW: Can I ask you about the composition of the population?

I just heard -- so, I was looking at the percentages from different ethnic groups. Are these similar to the population overall in your district?

So, it was, you know, so, it's 10.66 percent are Asian background, 28 percent white, 15 percent black, 45 percent white-Hispanic.

Would that mirror the overall population in your district or did you think --

JUDGE GEE: I think that mirrors the population of the County of Los Angeles, but it does, in some respects, reflect the prison population.

JUDGE SOROKIN: Just one thing. Just one other aspect that I think these programs offer that while the niche programs are small, there's a concept and I don't know the -- I don't have a suggestion for you as to who to use that and incorporate it into the guidelines.

But I think it's a significant concept, which is the choice broken down to a point where the person who is before you can possibly make a good choice, and build on that.

So, one of the things that these programs do is for the individuals is they break down, it's like, all right, I understand -- I used to say to people, I don't decide whether you go to jail. You do. You choose. It's what you do that directs what happens.

But it's on a small enough scale.

It's not over the next five years because if you look at the background of people, they haven't been able to make more better -- engage in that kind of long term planning and thinking and having to develop those skills.

So, I think that giving people smaller choices, so they can go down paths, good or bad, is a significant thing and then they can -- that doesn't mean to say that what happened before should not count. It does, but it -- whatever we build that into the system, I think it's a significant -- where we have expect -- we have expectations for people. We give people hope, which is very powerful modtivator of behavior and we have choices and consequences.

COMMISSIONER WROBLEWSKI: Right, we've been a believer in that for a long time. We have something called the drug intervention model, which actually started up in Boston and it's about calling in people. This is -- even before the --

JUDGE SOROKIN: Right.

COMMISSIONER WROBLEWSKI: -- and we even submitted --

JUDGE SOROKIN: Right.

COMMISSIONER WROBLEWSKI: -- but that's been spread, in terms of anti-gang --

JUDGE SOROKIN: Right.

COMMISSIONER WROBLEWSKI: -- but my question was all based on is that scalable?

Those call-ins involve dozens of people, you know, it's very resource-intensive. It is team-based. It involves the local team, it involves the prosecutor, it involves law enforcement, but it's small and --

JUDGE SOROKIN: I think it's scalable but it's --

COMMISSIONER WROBLEWSKI: Same thing with --

JUDGE SOROKIN: -- to think about it in a little bit of a different way, and I think that not every offender in the federal system

needs to be in a program like this.

But I think you have to think about who and what kind of problems you're trying to solve. I think if you're trying to solve drug problems, I think it is scalable, but not everybody in the federal system has a drug problem, and I think the first thing, I think all of our programs do this, is screen people with appropriate tools, with respect to their drug problems, and you're identifying people with a serious drug problem, because the research shows that actually people with a lower, small like they're confused a little bit and may have a drug problem and you don't want to put them in drug court, they'll do worse.

JUDGE GEE: Our program is not a drug court, it is for potentially a large range of criminal offenders.

But we have a large district --

ACTING CHAIR PRYOR: Yours is the biggest, right?

JUDGE GEE: Yes.

ACTING CHAIR PRYOR: In the country.

JUDGE GEE: Probably. We have four different judges who preside over their own teams, and just like in public school, where class size is important to how much attention you can provide to people in your class, I think the size is important, as well.

So, we -- we can't do a large program with hundreds of people at one time. On the other hand, when we have a group, and my group usually tends to be no greater than 20, we can then focus on individual needs and tailor our resources to the specific issues and problems that those people present.

So, in that sense, it's scalable, but you have to, in many ways, keep it relatively small, so that you can do the kind of focused intensive supervision that is so important to this program.

ACTING CHAIR PRYOR: We've gone a

little over, but we really appreciate your being here this morning and presenting.

JUDGE SOROKIN: Come visit. As Judge Hendricks said, I think you would learn a lot.

JUDGE GEE: Yes, you're welcome to come visit.

ACTING CHAIR PRYOR: Thank you for coming. Thank you. We're going to take, we'll take a break until 10 minutes after 11:00.

(Whereupon, the above-entitled matter went off the record at 10:58 a.m. and resumed at 11:10 a.m.)

ACTING CHAIR PRYOR: Okay, our third panel will focus on the dangers of synthetic drugs and their trafficking patterns.

First, we'll hear from Dr. Eric Wish. Dr. Wish is the director of the Center for Substance Abuse Research at the University of Maryland at College Park, Maryland.

Dr. Wish is also an associate professor at the University of Maryland's

criminology and criminal justice department.

Next we'll hear from Dr. Shontal Linder. Dr. Linder is the section chief of the synthetic drugs and chemical sections diversion control division of the Drug Enforcement Administration.

His responsibilities include managing a group of agents and diversion investigators and program analysts who work together to assist field investigations involving the trafficking of synthetic drugs and chemicals. Dr. Wish.

DR. WISH: Good morning, members of the Commission. It's really a privilege to come here and talk to you. I have to warn you, I have --

ACTING CHAIR PRYOR: I'm afraid that a red light is showing. It's not a green light. So. Is it on?

DR. WISH: I don't know.

ACTING CHAIR PRYOR: We're going. We're good, okay.

DR. WISH: So, now it's green.

ACTING CHAIR PRYOR: Thank you.

DR. WISH: Okay, I'm green with envy. So, look, I wanted to warn you, I have sort of a foreign accent. I have a Boston accent. So, some people --

ACTING CHAIR PRYOR: We're used to it around here.

DR. WISH: You are?

ACTING CHAIR PRYOR: Yeah.

DR. WISH: You know, I once went to a meeting with all the police commissioners, all these people from Boston, because we're going to set up a program there, and I said it would be cute, so I said I'm so glad to be at my home town, so I can talk to you and you'll all understand my accent. What accent?

So, anyway, but to just prove my accent, Commissioner Barkow, I know that's not the way you usually hear your name.

COMMISSIONER BARKOW: My mom says it

that way.

DR. WISH: So, anyway, I want run CESAR. I've been running it for 26 years. It's an interdisciplinary research center at the University of Maryland and listening to the prior panels, I decided we have the easy job.

We define the problem. You have, most of the people in the room have the problem of trying to fix the problem, which is much more difficult.

But any time we can feed scientific information into policy, we want to do that and try and inform the debate.

So, just to tell you little about me. I was a visiting fellow at NIJ in Department of Justice in the 80s, launching the drug use forecasting, which later became ADAM, which is based on collecting urine samples from offenders regularly, identify -- to track emerging drugs in society, because in -- I know we have research that shows giving advance warning of a drug

epidemic.

So, I'm going to be getting back to that in a minute. But anyway, we are running a program like that called The Community Drug Early Warning System, or the CDEWS, and I apologize for the jargon and the awful -- that's that way it is, and that analyzes urine samples from high risk populations.

So, we're able to find out what these people actually take, and there's no one else doing it on the type of scale that we're doing it.

In addition, CESAR is the coordinating center for NIDA NIH National Drug Early Warning System and basically I invite you to go to our website which is NDEWS.org and we have the job of working with experts around the country and trying to keep track of emerging drugs and then putting it all in the way that people would disseminate the information in a timely basis.

I have with me my deputy director

Erin Artigiani, who if you stump me, she may come over and I may ask her to answer the question.

So, I want to take a few minutes to focus on the study we've been doing, the ONDCP that's the Office of National Drug Control and Policy and we collect urine samples from drug testing programs operating in the criminal justice system treatment and also treatment centers.

What we found is that most of these programs are testing for the drugs from the last epidemic and they can't even go, they don't have the capability of tests for the new emerging drugs that we're talking about today.

So, basically we collect the sample these specimens to identify, and we send them to a laboratory we've identified, and they're ready to be thrown out and we send them to a laboratory and test them for 150 substances.

So, we keep modifying our panel so that we are on top of the latest drugs that are

-- that we think are coming out.

So, I have been studying drug problems all the way back to graduate school and we studied the Vietnam Veterans to find out if they were going to bring their heroin problem back to the states, and I've been doing a lot urinalysis studies.

I've never seen anything like the problem and the challenge of these synthetic drugs. I used to be able to call a laboratory and say did -- take these specimens and test for this standard panel, and when we started out, it was nine drugs, nine common drugs.

But what happens is that as these new drugs which are originally legal, and they are put on the federal schedule and made illegal, the people who are creating these tweak the molecule, so it's now legal, and so, it's really hard to keep up with these substances and what basically happens is the DEA tracks the parent drug, what's there before it's ingested. We're tracking the

metabolite and when you find one of these drugs, you don't know how the liver metabolizes it.

So, then they have to go into NIDA's laboratory where they can mimic the liver, break down the drug and then tell the test companies here is what you need to create, to be able to test for this new drug. It's a whole new ball game. I've never seen it before.

So, we currently on the list, we started out with ten substances. We now test for 26 synthetic cannabinoids, we never, by the way, call them synthetic marijuana, because anything that's synthetic usually means it's good, right? This is not marijuana, all right.

So, we call it synthetic cannabinoids and these drugs, because they're so new, no, there's no FDA study. There's no research on them. No one knows what they can do to the body and the brain. It's really dangerous, okay?

So, I want to just tell you some of what we've been finding as we go around

collecting these urines from high risks groups.

The first thing I want to tell you is the metabolites keep changing. When we got out -- first time we did this, we called the lab and said, all right, we're going to send the specimens and we want to test for these 10 metabolites. They said to us, you know, the people who create this, they've changed it because it's now illegal. You'd better add these two new metabolites.

So, we added it. So, we had 12. If we hadn't added those two, we would have missed 95 percent of the positives that we found in that study, okay?

So, we literally do a survey of toxicologists around the world and law enforcement, scientists to find out what should we be testing for, and sometimes we had to hold the specimens up until the new tests are available, all right?

So, anyone taking Spice or K2, so, any

of these surveys, anyone we talked to had no idea what they took. Zero idea. All they know is they took something that's packaged in a certain way and someone said it's quote synthetic marijuana. They had no idea.

Therefore, they're playing Russian Roulette with their body and you see the media reports that have been happening with people coming into the emergency room.

So, also we've gone into Washington, D.C. and done a lot of testing with the PSA group, pre-trial services. The metabolites vary both by site across the country and within site over time. They keep changing, okay, as these new -- as these new things are done.

You know how they say politics is local? Drug use is local. That's why taking an average survey doesn't work in terms of really tracking this.

I also want to tell you that you might think that legalization wouldn't use these drugs.

Well, legalization makes marijuana expensive. So, if you could find these drugs on the street and it's cheaper, they're still using them. They're using them to avoid detection by testing programs, and I was going to come in here and tell you today this has peaked, because in the D.C. area, the stats are down, and then couple weeks ago, a huge outbreak of people going into Austin's emergency departments with this problem and who is using? The homeless population. It's real cheap.

I think that the more educated have gotten a notice on this and perhaps they're not using it. I also -- my final things I wanted to say to you is I've looked over the material that you have on the laws.

You talk about specific chemicals. You can't do that. It's obsolete as soon as you do it. The main factor, the chemicals that you're talking about we don't find them anymore, that JWH-018, that's not what people are using.

So, you need to focus your rules not on the chemical structure, but more on the characteristics of these drugs, how do they look like? What was the intent in selling them? Are they sold to kids, and in fact, some of the jurisdictions now have gotten away from writing laws based on the chemical structure, and instead are saying, all right, it looks like synthetic cannabinoids, it's sold like that, if it says it's not for human consumption, if it's more expensive and it's sold for kids, then they have an ability to perhaps close down a retail establishment for a while, all right?

It's not based on the actual chemical test. Thank you.

COMMISSIONER BREYER: Are you saying that the -- I'm fascinated by this, well I did so poorly in chemistry.

DR. WISH: Yes.

COMMISSIONER BREYER: That my questions may evidence that -- but are you saying

now, look, throw out those chemical definitions? They're not working and what is going to be substituted in its place? I'm trying to sort of follow that.

DR. WISH: I'm not sure I understand --

COMMISSIONER BREYER: Well, you look at the chart. You look at -- you look at the sentencing guidelines. They look like a chemistry --

DR. WISH: Right.

COMMISSIONER BREYER: -- quiz, okay, and I don't pay -- I never have.

DR. WISH: Yes.

COMMISSIONER BREYER: I'm trying to figure out, however the law is designed to be exact in this area --

DR. WISH: Yes.

COMMISSIONER BREYER: -- that is you -- you have 'x' and you're -- or you're alleged to have 'x'. 'X' has these qualities. You're

going to be prosecuted.

So, you say now, 'x' is now 'x' plus 'y' plus 'z' and it doesn't even look like 'x'.

DR. WISH: That's right.

COMMISSIONER BREYER: Well, then what are we supposed to do now? What is your --

DR. WISH: I told you I had the easy job.

COMMISSIONER BREYER: Yes, I have the --

DR. WISH: It's in the --

COMMISSIONER BREYER: I'm asking you really this. In terms of definition --

DR. WISH: Yes.

COMMISSIONER BREYER: -- so that so that a -- a -- a --- so that everybody out there knows a definition, what is now the definition that we should -- that -- that you're telling Congress, I guess to do, to use for these drugs?

DR. WISH: That's a great question and I think I'd have to sit down with a lawyer to try

and craft something, but it's not based on the chemistry. It's got to be on the intent, how it's marketed and who's marketing it, and believe me, it's a cat and mouse game. What? That Whack-a-Mole game. You take this. You make this illegal. You put penalties on it. They switch it and it happens so fast, I can't keep up with it.

As someone who follows these trends, tries to do it, I can't keep up with it. I have to wait for the chemists to develop the new test. It's totally a new thing, and you know, just think about it.

So, even if you read it in the newspaper and they say someone took synthetic marijuana, they say, I don't have any idea what the person took.

Now, when I talk to people in emergency departments, they're not really bothered too much by this. They treat the symptoms. It doesn't matter which specific

chemical they took. They just treat the symptoms.

But if you do have monitoring program, like some of your probation programs are doing testing, what we're able to show is, we go into these programs and all the drugs are missing -- and they -- and some of them like we got into Tampa, and we tested juveniles and we found 144, which they weren't testing for, so now they include it in their test panel.

D.C. pre-trial, based on our research that we did, has now modified and expanded what they test for. So, you have to decide the cost-benefit of testing for this.

But in terms of writing laws, I don't really have a good answer for you.

ACTING CHAIR PRYOR: All right. Why don't we hear from Dr. Linder?

DR. LINDER: Good morning. Again, I'm Shontal Linder and I manage the DEA synthetic drugs and chemicals section in our headquarters

and what I want to do this morning is kind of give you an overview of the trafficking patterns of the synthetic drugs and kind of what DEA has been doing to combat the problem.

So, want to thank you again and members of the Commission for opportunity to discuss the risks proposed by trafficking and elicit manufacturing drugs, but they also called NPS. Mostly internationally is what they call new cycle active substances is what -- it's the other name for them.

So, these substances are flooded into the United States and they don't -- not only put adults -- our adults is in the risk, but also our children for permanent injury or death and so, the significant -- this is significant problem for DEA and it's overwhelming our law enforcement.

So, the synthetic cannabinoids and cathinones are easily available through various outlets, we're talking about the internet,

convenience stores, gas stations, street dealers and drug trafficking organizations. All of those methods.

So, anyone is easily able to order substances directly to their doorstep, they're on the internet. They're probably manufactured in China and imported to the U.S. by common carrier. They're produced by foreign chemists and shipped into U.S. into U.S. usually in powder form and after entering the U.S., the cannabinoids are usually mixed with -- dissolved with acetone and sprayed in an inert plant material and mixed with flavoring prior to distributing the substances.

The cathinones are commonly sold in capsules, tablets, or powder form, and they're packaged, both of them are packaged for distribution in various brands in the manner that is usually appealing to youth. You have like the for instance, the Scooby snacks or Cloud 9, very colorful packaging that they usually cater to the younger people.

So, they are made in these domestic warehouses locations and then distributed throughout the country.

So, the U.S. distributors of these substances, they can range from large multi-scale drug trafficking organizations or to individuals who either package the substance for resale in small quantity or distribute them in kilogram quantities as well and they can -- they business is very lucrative.

So, for example, one kilogram of synthetic powder can be purchased from China from $2,000 to $5,000 per kilogram. So, if that substance is broken down into packages and sold for $20 each, at one to two grams per package, then the traffickers, they stand to profit of $250,000 just for that one three two $5,000 investment.

So, the process of manufacturing these synthetic drug -- concepts -- it's very unstable. Is what I would like to really bring home to you

because when creating and mixing these substances, there is no way control to the method. So, as a result, the packaged substances, it various levels of concentration, and one single package, it's what we call hot spots.

So, what we mean is that you can get one package and then one portion of that gram package can be a higher concentration than the rest of it and it can cause death.

So, as a result DEA is -- we have consistent work with our foreign, state and local law enforcement partners to impede the synthetic drug trafficking in the U.S. and we conducted several large scale investigations that include most with the DEA foreign and domestic offices and operations in operations such as Operation Log Jam and Project Synergy, where we used traditional and covert operations to identify a risk and seize the assets of these traffickers.

For your knowledge, according to the

DEA national forensic laboratory information system or NFLIS, which is the program that I think Dr. Wish talked about, that collects drug identification results from drug cases and logs the federal, state and local forensic laboratories, there were 706 total encounters in 2015, and 1,014 total encounters in 2016 for the five substances that we are talking about today. They're under consideration at this hearing.

We investigated a case in New York where we seized over five kilograms of methylone from an organization that obtained their substance from China, and they resold it on the dark web and distributed throughout the U.S., and from this case, resulted in numerous overdoses in students at the University of New Hampshire.

We had another case in Lafayette, Louisiana. Defendant sold synthetic substances including AM-2201 and they had several businesses and through these -- through these businesses they distributed all these different types of

synthetic substances, and the defendants and the co-defendants distribute published instruction to other retail outlets on how to interact with law enforcement, sell them these substances on the rusee that the substances were not for human consumption. So, they're providing guidance to other retail outlets to thwart law enforcement.

So, our experience shows that the sentencing proceedings for synthetic substances involve lengthy and complex hearings and which multiple scientists opine on the most-closely related substances in sentencing guidelines.

In this situation it presents challenges for all the parties, the government, the defendants and the court, as well. So, it's extremely resource-intensive and leads to inconsistent outcomes, as you all know.

So, therefore, we are in need of your help to establish guideline equivalencies that consider both scientific information and the harm to the community that result from the trafficking

of these substances.

The various methods of the synthetic drug trafficking has evolved in something that we, law enforcement has never encountered, and this is one type of drug trafficking that covers all facets, and we cannot narrow it down into one, and we're in need of assistance from law makers to assist us in this battle, and the DEA is committed to doing everything we can to address the threat, and will continue to work with our foreign and domestic law enforcement partners.

So, but thank you for your time and I be happy to take any questions you may have.

COMMISSIONER BREYER: Well, I'd like to ask did you concur in this rather dark statement that look, we -- they're way ahead of us and they're continually changing one molecule to whatever they do to this, and then therefore, it's not enforceable against them because --

DR. LINDER: That's the reality, sir.

COMMISSIONER BREYER: Is that your experience?

DR. LINDER: Yes, sir. As soon as something gets controlled, the traffickers are right, especially in China, if we're caught saying that we're -- they're ready -- prepared to get something different that cannot be seized.

COMMISSIONER BREYER: So, can you tell us from the DEA's point of view, what actually happens when you -- when you -- there is an arrest for what appears to be a drug deal, large quantity of drugs and then it's tested and it's found to be not on this chart, what do you do?

DR. LINDER: Then we try to use the analog act, where we try to do the comparative substance for causes physical -- physiological or psychological in other chemical drugs to compare it to -- to -- to use in court.

COMMISSIONER BREYER: And how successful has that been, that exercise?

DR. LINDER: It's been very successful, but there are challenges because of the -- the -- the various testimony that's needed, that the -- it becomes a scientific battle at that point between the government and the defense.

COMMISSIONER BARKOW: Can I ask you -- so, from our perspective, here is my fear.

You know, we're going to have five of the drugs that you know, we're told now we should be studying and as soon as we issue whatever guidance, there will be the five new ones, and so, won't it just mean you're back in court doing the same testimony with the same scientific battle, because we'll also be behind the curve with it.

I just have a hard time figuring out what it is that we at the Commission can do, that's any different than what you're struggling with because --

DR. LINDER: Nothing, that's exactly --

COMMISSIONER BARKOW: -- I can't figure out how we would say drugs like that -- I only -- I guess -- and you have no thoughts on that either, do you?

DR. LINDER: Yes, it's just like I mentioned, it's a battle we've never seen before, you know.

As soon as we, you know, think we have a handle one drug, they create something else and then since we don't have a law that covers something with an umbrella effect of it, we keep fighting the same battle.

COMMISSIONER BARKOW: So, if we were to give you guidance on let's say, five of the things that are out there now, you know, whatever -- whichever one we could identify now, does that move the ball forward for you at all, in terms of then the next generation of the new five they come up with, because that would be a closer analog than what we currently have or does that -- is it kind of just of a modest affect, in terms

of helping with this?

DR. LINDER: Well, I think it helps because it gives us a new comparative, something that's more closely related because we shouldn't be using marijuana everything because it's not marijuana at all.

So, this will allow us to have a better comparative.

COMMISSIONER SMOOT: Let me just ask a real question. Do any of the states -- have any of the states come any closer than the feds to try to develop some law that would capture at all? Are there any states? Is there any guidance at all?

DR. LINDER: Yes, there are some states that have state laws that have, like I mentioned before, come out the umbrella effect for the synthetic drugs. I'm not versed on how they write it, but they do write it in a way when it -- it doesn't include individual substances like the same effects or the same -- I don't know the

-- yes, some states do have --

ACTING CHAIR PRYOR: Do you know which ones?

DR. LINDER: Not off hand, no.

ACTING CHAIR PRYOR: Okay.

PARTICIPANT: That would be helpful.

DR. WISH: We have the Washington D.C. program, I mentioned, which basically allows them to shut down a retail establishment that appears to be selling a synthetic cannabinoids.

COMMISSIONER SMOOT: No, I'm familiar with that, and they also -- additionally, there's a problem with those people, they're under supervision and on parole, because we can't catch them, because the drugs that -- we have a certain number of drugs that we're testing for, and we know they're something, but we can't figure out what it is because it's one of these substances. It's very difficult.

DR. LINDER: Yes, and we have presumptive test too, in the field, because it

keeps changing.

COMMISSIONER REEVES: Because we're looking at this targeted population use, should we probably be looking at this more in terms of an aggravating factor, when we come in contact with synthetic drugs, as opposed to the traditional drugs?

We're trying to compare -- I know you don't like to use the term synthetic marijuana, but to marijuana, should the synthetic version have some aggravating factor over and above the comparable drug? Does that discourage production rather than allow the producers to change the molecule?

DR. WISH: There's no scientific clinical evidence on these drugs. Just can't -- you know, it takes a while to figure -- to give people these specific drugs and see what the impact is, and then it's not really like that for the synthetics.

But you have a short history. That's

the problem. In fact, I think I know it's beyond your purview, but perhaps what we can do is launch something like we did about crack cocaine, which is your brain on drugs, that type of thing, and educate the population about this Russian Roulette issue. You really don't know what you're taking and it's incredibly dangerous.

The numbers of people that go into an emergency department in a locality over a weekend because they all use the same thing it's just -- it's startling to see these statistics, and you just don't know, because I said, as multiple things in it, it keeps changing. You can't really say whether it will affect you one way or any -- or you another way. It's just -- that doesn't exist.

ACTING CHAIR PRYOR: Well, I want to thank you for your presentations this morning and --

DR. WISH: Can I add one thing --

ACTING CHAIR PRYOR: Sure.

DR. WISH: -- because I listened to a committee, we were listening to drug courts and we were listening to people talk about drug treatment and what I want you be aware of, we found this with the Vietnam Veterans who used heroin and the people who use heroin, and there was people -- and I replicated this in many populations.

The people who use the less, I'll say rare drugs, right, have used everything else. We recently for NIDA a hot spot study of fentanyl, fentanyl overdose death people in New Hampshire, and they sent us the urine, it's 136 urine, and when we ran it through this 150 drug screening, the average -- the average number of drugs in these people when they died was close to four.

So, we'd like as a society, to blame the demon drug. We've been doing this my whole career, but it really isn't about the drug, it's about the person using it and having this type of a disorder.

So, what I'd urge the committee to do is when you start reviewing treatment programs, look for treatment programs that look at the whole person, that acknowledge the fact that the person using heroin is probably using a whole lot of other drugs and you need to address -- you want to be successful. You need to address the whole panoply of drugs the person is using and not blame it on one drug.

ACTING CHAIR PRYOR: Thank you, Dr. Wish. Thank you, Dr. Linder.

We have one more panel before we break for lunch.

Our fourth panel will give us the perspective of law enforcement, emergency care personnel and probation supervisors.

Our first witness will be Captain Osvaldo Tianga. Captain Tianga is a 20-year veteran of the Broward County Sheriff's Office, who currently serves as the court services commander for responsible for the day to day

security and operations of all circuit and county courts in Broward County.

Additionally, Captain Tianga serves as the Agency's synthetic drug expert.

Dr. John Cunha?

DR. CUNHA: Cunha.

ACTING CHAIR PRYOR: Cunha, is the vice chief of the emergency department of Holy Cross Hospital in Fort Lauderdale, Florida and is also the medical director of the emergency medical services for the City of Oakland Park, Florida.

Finally, we'll hear from Dr. Lisa Rawlings. Dr. Rawlings is the chief of staff at the Court Services and Offender Supervision Agency for the District of Columbia, which is a federal executive branch agency that provides supervision and support services to adult offenders on probation, parole and supervised release in the District of Columbia. Captain Tianga.

CAPTAIN TIANGA: Good morning. It's still morning, right? Yes.

Well, thanks for having me. I appreciate your guy's time and attention to an issue that I'm very passionate about. Like you said, I've worked with Broward Sheriff's Office for almost 20 years. I started very young and most of my career has been in narcotics, and it wasn't until recent times where we became involved with these synthetic drugs, and I hear all these questions that have been posed to me many, many times and you know, and Dr. Cunha and I, and I'll get into that later, we were sitting back there poking each other, wanted to raise our hand like, my turn, I think I have the answer to that question.

So, hopefully I could be of some use to the panel. But as we -- as -- what we do know about synthetic drugs, it's been around for a long time. It hasn't hit us as hard, but you know, even at the last presentation, they were

talking about methylone, and methylone was my first introduction, not really first, but when it started to get so severe, methylne was basically a drug who, when the streets was referred to as molly, still very common term used on the streets, although methylone is hardly found like it used to be, but molly was known as pure MDMA. MDMA being ecstasy and molly had more of a euphoric high. It had more of a amphetamine-type high.

So, consumers or drug dealers would say, well, molly is just pure MDMA, and that's why you get this more -- this higher high, if you will, which was completely false. It did give you the euphoric feeling that the user was intending to get, and because it was stronger, they said it was pure MDMA. Wasn't the case.

As molly evolved and the government caught up with it, molly was mass produced in China. China outlawed the production of methylone, so they needed a new substance and

this is when they started to be -- to mess with the molecular structure of drugs, and that's how at least in Broward County, that's where I serve. That's how we were introduced into alpha-PVP, some known as flakka.

Alpha-PVP or flakka again, had a tremendous amphetamine type property to it, a tremendous high, and if consumed orally like molly mostly was, like a pill, you just go even higher.

So, now, it became a more pure and more potent. The problem is users now noted you could smoke it, inject it, snort it. It was the one size fits all drug, and based on how you consumed it, it gave tremendous, tremendous effects.

Not only tremendous effects, but tremendous confusion. Not only tremendous confusion to us in this room as it's doing today, but to the drug dealer who didn't know what he was selling, to the drug user that didn't know

what the appropriate dosage was.

To the law enforcement officer on the street who encountered it, and didn't know exactly what it was, and not only that, but to the street -- the street level tests, the field tests that we use on the street, it would give false positives.

flakka, for example, field tests positive even today for cocaine, heroin and amphetamines. So, because it was so potent, because it was so strong, from a law enforcement perspective and from many professionals out there, we would give testimony that it was all drugs. It was just every drug mixed together, and that's why we were getting the side effects that we were getting and it was causing such devastation because we had no idea what was about to happen or what was currently happening.

It looked like many other drugs. It basically looked like whatever the drug user wanted it to look like. If you wanted it to look

like marijuana, it could be broken down and sprayed onto the damiana plant.

If you wanted it to look like cocaine, you could make it in powder form and snort it. If you wanted it in heroin, it dissolved in water. So, whatever you wanted it to looked like, it looked like.

Then as from a price perspective, a kilogram of flakka at the time was about $1,500 and you could say very comfortably that flakka is ten times more potent than cocaine.

At the same time, cocaine was being sold on the streets, a kilogram of cocaine was $30,000. So, here you are buying a substance off of the internet at $1,500 a kilo, and in contrast to cocaine, which is $30,000 a kilo, and the difference was, if flakka -- first of all, when flakka was first introduced it wasn't even illegal. But even when it was the penalty -- the penalty -- even today, the penalties are so small, that it's worth the risk and it's the

mailman that delivers your drugs, not some drug dealer in the middle of a bad neighborhood who is probably going to rob you or sell you some fake stuff.

This was guaranteed delivery and if it didn't deliver, you call China and tell them they didn't deliver the substance, and they'd deliver it again.

So, there were tremendous -- tremendous problems with that.

On the street, crack cocaine, for example, $20 rock of crack cocaine keeps you high for 10, 15, 20 minutes tops, if it's good stuff.

A five dollar rock of -- a $5, which is a smaller rock of flakka, keep you high for four to six hours. So, not -- and then the side effects that came along with it, we coined the term in the office calls is the $5 insanity, because of the side effects, which I'll get into next.

Basically, it turned people into

zombies, and our streets were flooded with them, all ages, all ethnic groups. It was no target -- I know somebody used the term target. Who are we targeting here?

There was nobody to target. We had kids ordering this off the internet, just like we had long term drug dealers. There was no -- what you needed to be a drug dealer, let's say 10 or 15 years ago, where you had to be involved with the family and start from the bottom and they want -- the typical drug dealer starts on the street corner and then he moves up to mid-level drug dealing.

He stays there for a while and then finally, he gets his chance, if he doesn't go to jail or get killed, he gets his chance to be a large-scale drug distributor, which takes lots of money.

Somebody could be your overnight internet drug dealer, selling kilograms amounts of drugs, with very little money and very little

risk because again, when flakka first came out, it wasn't illegal.

Now, we get into the side effects, or the effects. The effects, and I'm not sure if you guys spoke about this earlier, but it was basically like I said, zombie effects.

Side effects of flakka, the number one thing it did was increase body temperature. Because it increased body temperature, people would take their clothes off.

So, now, we have communities with people running around naked, acting very psychotic, paranoid. So, it -- I'm sorry. It overwhelmed us, it really did, and we didn't know what was going on, and that's how we were introduced to the hospital, because we had nothing to do.

These people were not criminals. They had committed no crime. They consumed the drug already, and now, they're out in this zombie like state of mind. The only thing we had to

turn to were the hospitals.

So, here you go with law enforcement trying to subdue these individuals who are paranoid already, using basic police techniques which always encompassed some level of force, to inflict pain, to get somebody to comply.

Well, in these -- in this state of mind, they have no feeling of pain, and I tell you that first-hand, boots on the ground, where we've twisted the arm of a female who was 105 pounds and her arm pops and everybody lets her go and she stands up and is still swinging her pop, and her arm is popped out of her socket.

So, we were confused. Confused. We didn't know what the drug was. We didn't know how to diagnose it. We didn't know what was happening to our community, and now, we have the community asking us what's flakka? What's flakka?

Like I said, initially we would tell them it's a combination of heroin, it's a

combination of cocaine, crack, it's all put in one, but it never made sense to me because it was so much cheaper than all those other drugs in original form.

So, for them to sell those drugs and a combination would obviously make it more expensive, which it didn't.

So, the main effects or the worse effect was that excited delirium, it gave people super-human strength and initially, when we approached our community, we had actually a picture of Superman, of somebody on the drug, and we changed our momentum, because we didn't want kids -- I'm sorry, I didn't know there was a timer.

ACTING CHAIR PRYOR: There's a red light.

CAPTAIN TIANGA: I apologize.

ACTING CHAIR PRYOR: That's okay. You can, you know, finish your remarks, if you have a way of wrapping it up.

CAPTAIN TIANGA: I'll just -- I'll close in saying that currently, and the challenges that you're facing is the juice is worth the squeeze. If you're going to be a drug trafficker, a drug distributor in today's -- in today's society, you'd be a -- you will be a synthetic drug dealer because the penalties are just not there.

State attorneys, federal prosecutors, we do in Broward County, State of Florida, do have a law, the analog law, that's the umbrella law that covers anything -- everything.

Nobody wants to prosecute it. Nobody wants to move forward because it becomes a battle of the sciences and a battle of the unknown. You have -- you're forcing attorneys to become doctors and scientists, and introducing this and trying to sell that to a jury becomes almost impossible.

So, currently right now, for the drug dealer, the juice is worth the squeeze. It's much

cheaper, much more potent and which makes it much more important for us to make the penalty stiffer, like you said, on these drugs, so we deter these people from selling these drugs that we don't know, and go back, at a minimum, to selling the drugs that we do know how to enforce and we do know how to fight.

Thank you, and I apologize for going over time.

ACTING CHAIR PRYOR: That's okay. No, don't. No problem. Thank you.

DR. CUNHA: Thanks, Commission, and thanks, Ozzy.

I'm Dr. John Cunha. I'm an emergency room doctor. I practice emergency medicine. I'm also an emergency medical services medical director for EMS. So, fire rescue and training, fire rescue in the area around Fort Lauderdale.

I'm also the -- one of the advocates in Broward County that went out with Ozzy and went literally from churches to schools, to get

the word out about these synthetic drugs, and that's how I met Ozzy.

So, taking off from his story, he's finding these things on the streets, and they're devastating the communities. He doesn't know what they are. He doesn't know how to treat them, and my paramedics actually came to me in November of 2014 and said, "What is the flakka stuff and what do we do about it?

So, I made a PowerPoint that ended up on YouTube, to teach paramedics how to treat excited delirium, and somehow that's how I became involved in these talks, going forward.

So, let's say you have this 110-pound woman on the street who it takes six deputies to take down. What happens to them afterwards?

Well, I am the one who gets them in the emergency room afterwards, and this is where even the story sort of begins to the devastation that it causes these people, and it causes our emergency health system okay?

So, take a typical EMS run, fire rescue run for a medical patient. In our county, it takes between 20 minutes and 40 minutes to go see the patient, pick them up, bring them to the hospital, drop them off and get back into service. That's just a usual run.

If you have to wait on the scene for the scene to be safe, you have to wait for five deputies and take a person in excited delirium who can't think straight, can't talk straight, is acting crazy, is naked, is slimy because they're sweaty, is taking swings at you and thinks that you're there to harm them, which is what these synthetic drugs do across the classes, the cathinones, the cannabinoids, the other synthetics, they all have a stimulant effect, a speed-like effect, amphetamine effect, and when these patients overdose, they are critically ill, and they can't help themselves.

So, you take a patient who has -- you have to have safety, you have to five or six

people taking them down, and then they have to be strapped to a board and medicated to safely go to the hospital. That takes an entire long process. So, now, you're talking about EMS runs of 90 minutes, taking crews off the streets.

So, instead of 30 minutes, they're taking three times as long, just to drop these patients off. That's just the beginning.

Now, I have a patient in my emergency room who is flailing around, flashing. They are a risk to themselves for harm. They're a risk to my staff for harm. They're a risk to me for harm, and often they take resources of the entire emergency department away from other people to take care of them and save their lives.

Then if I am successful in saving their life, using a number of different medical techniques including intubation, medication such as Ketamine and other benzodiazepine to try and knock them down, then they often spend several days in the emergency -- in the hospital

admitted, or even in intensive care admitted.

Then when they're awake enough and out of their delirium, some of them sign themselves out against medical advice, go back on the streets and do it again, or if they are successful in getting their lives being saved and they get out successfully discharged from the hospital, they then end up going back out on the streets and doing it again, because these drugs are cross the board, again, having very addictive potency.

We'll have patients that tell us, "I took flakka. It was the worst high of my life, but I'd go and do it again because I just can't help it."

So, Commissioner Breyer and Barkow, you asked a question to the previous panel about what can you do for these broad chemical classifications.

At the very least, you have to have these broad chemical classifications banded wholesale as broad chemical classifications, but

also look at the Florida analog law, the analog act, which really helped Ozzy and his team take some of these chemicals off the street and prosecute because you can't do it individually because they just go from drug, to drug, to drug.

ACTING CHAIR PRYOR: I thought you just told us that no one wants to use that law, because it becomes a battle of the experts.

DR. CUNHA: It's the best thing you have and maybe you can tweak that a little bit to get to -- to where you need to go, but it has to be broad classifications.

Often we don't even know from our drug testing, what these patients took. Our drug testing is only limited in the emergency. Sometimes we have to wait for them to wake up, for them to tell us what they took.

So, it's very resource-intensive. It is dangerous to my staff and the EMS workers and the police officers in the street, but it also is devastating to the patients because they have

very poor rehabability after they get out. They're very paranoid and it's a long-term paranoia.

Some of them who have excited delirium actually have renal failure, go on dialysis long term. They have lung problems. They have cognitive issues and they can't rejoin society.

There is a cadre of patients in Broward County that have these things happen. This is not your typical marijuana. This is not your typical cocaine. These things are highly psycho-active and they're highly long acting results afterwards.

COMMISSIONER BREYER: Are they -- is part of the problem that the other drugs deemed illegal, marijuana or whatever you want -- whatever classification you want to take, those drugs being illegal has now forced the developed of this other -- of these synthetic --

DR. CUNHA: Correct. Correct. So, if you looked at -- if you -- if you take South

Florida Broward County as a microcosm, we had the opiate pill mills.

When the opiate pill mills were run out of business by making laws, then it became the synthetics, molly, MDMA, methadone.

Once that was run out of town, it became flakka and bath salts. Once they were run out of town, now unfortunately you have the synthetic heroin, because that population that wants to get high is going to get high at all costs.

When it easy two dollar Percocets on the streets, that's what they used. When it is easy to get three dollar flakka on the streets, that's what they used. Now, it's the synthetic heroin, and they just keep going down the line.

They're going to get high no matter what you do, unless you interact or keep them from getting high, or help them to get off of getting high.

Short of that, they're going to take

the path of least resistance to get these drugs and you're just going to keep going down the line of drug after drug after drug after drug.

ACTING CHAIR PRYOR: Dr. Rawlings.

DR. RAWLINGS: Good morning, and thank you for the opportunity to share our testimony.

As I mentioned, my name is Lisa Rawlings. I serve as the chief of staff for the court service and offender supervision agency. We provide community supervision here in the District of Columbia.

Just so that you can understand the impact of synthetic drugs, I just want to talk a little bit about the work we do and how we approach supervision, so you can fully understand or appreciate the impact.

Our supervision terms vary from about nine months, 19 months on average for probation, up to about 12 years for people who are on parole. So, we see these individuals day in and day out.

For the people at the highest risk, we see them twice a week, and at the lowest levels, it may be once every two months.

So, we have this ongoing relationship with folks who are involved in the criminal justice system. We do focus on accountability and really promoting individual change and we use evidence-based approach supervision that includes a valid and rigorous assessment protocol to determine the likelihood for re-offending.

This drives our supervision strategy, which has some of the most stringent contact standards in the nation.

We also apply evidence-based supervision strategies for our graduated responses. So, sanctions for offenses and sentences for noncompliant behavior.

Our supervision offices employ cognitive behavioral based interventions in order to interrupt these patterns of thinking, and to ultimately change behavior.

I wanted to provide the context, so you can understand how when synthetic drugs are introduced into this population, the impact it can have and disrupt and actually undermine our total supervision process. So, I'm going to talk about three different ways in which that happens.

First, we've had a lot of discussion about the challenges around detection and testing. In addition to the inability to really have some confidence in the testing protocols because the elements are continually changing, it's also a tremendous cost.

So, for us when we have gone to full scale universal testing of synthetic drugs, our drug testing costs increase 40 percent one year over the next and that's an ongoing cost, so we have to absorb, and what we're seeing right now is that for all the -- for all the individuals that are tested, all the samples that are tested, we see about a one percent positive rate.

So, we can't stand on the fact that

maybe the prevalence is declining, but it's just that maybe our protocols are really not keeping pace with the current usage patterns, and this is just for synthetic cannabinoids.

We have not even been able to introduce synthetic cathinones and some of the other elements.

In addition, as the compounds are changing, the drug pattern usage is changing, as well. So, when this was introduced into the leadership in 2012, we had been focused on synthetic cannabinoids.

What we found subsequent to that, while we'd been chasing synthetic cannabinoids, the population -- the usage patterns have been changing and so, in D.C. in particular, they've gone from synthetic cannabinoids to then the cathinones, and now to the synthetic opioid.

So, we're still focused on the synthetic cannabinoids, and so, we're constantly trying to stay, you know, to keep pace with these

evolving -- not just evolving compounds, but then the evolving usage patterns has been a tremendous challenge.

In addition to that, when it first came to our attention, synthetic drugs was -- they were using Scooby snacks and K2 marketed -- they looked like pop-rocks, and what they colloquially referred to them as parole packs, specifically because these were appropriate for people who are on parole, parole or probation because they could not be detected.

So, it's almost a perfect opportunity for someone who is under supervision to -- to subvert and to undermine the supervision process.

So, we talked about the challenges of the intoxication that is used in the -- the effects that it can have. We're obviously concerned about the safety it can have on our officers, most in the office because we have even -- we even have people reporting to supervision, telling their officers that they have used some

kind of synthetic substance and that's how, you know, it was kind of brought to our attention, because it was not -- it was not something that was illegal at that point in time.

So, then the safety concern, when they're going out on the home visits and they're used in the home, it looked -- that again, presents another concern, and then we talk about what is the purpose of supervision. It's really to help change behavior and if we're using these evidence-based strategies that are targeting thinking patterns and behavior, and if you have people whose thinking patterns and thinking capacity is undermined, then that's really not going to be very effective.

Then again, if you're focused on strict accountability and these are the standards, and if we're testing and they're using and we can't stand confidently on whether or not we can detect if they're testing or not, then it really reinforces, you know, their ability to use

these substances.

So, it presents a number of these challenges, and then again, their treatment again, you know, is varied.

So, previous panelists talked about, you know, kind of addressing the underlying causes of substance use, but then we don't know enough about these compounds to really know if there is any specific kind of intervention that may be needed or if there is any, you know, specific maybe medications that may help assist in the treatment of it.

So, in the District, one of the things that we did do when it came to our attention, we pulled together a city-wide task force and we took a very comprehensive approach, which did include legislation. It also included regulation and working with the police department, the health department as well, to have a really aggressive approach to the outlets that sell synthetic cannabinoids at that point in

time.

So, we have seen a change in those patterns again, the usage patterns have been changing to keep pace.

So, just in closing, I would like to say that when the community supervision is to be a public safety -- safety net, then really the introduction of synthetic drugs, you know, really undermines the fundamental purpose of what we try to do every day.

ACTING CHAIR PRYOR: Captain, I cut you off early. I don't know if you had anything else that you had -- that you'd like to say. We've got about 10 more minutes before --

CAPTAIN TIANGA: I appreciate it, and they covered it very eloquently.

I will say that just the -- the undermining of the drugs tests, the kit itself, I have judges, I oversee court services now and I oversee 104 different judges, and I'll get calls from the courtroom of individuals who are

on probation and parole, and the judge knows that this individual is under the influence, has drug tested him in the courtroom, or aside from the courtroom, and they come back completely clean, and I'll pull them aside and talk to them and they're like, "Hey, I smoked a synthetic. That's all I can tell you. I got high, you know?"

But it definitely happens and that's why people are turning to synthetics, especially those individuals on probation and parole or our kids that are drug tested by their parents, because everybody knows you to the pharmacy and buy your home drug testing kits, which say they test for synthetics, which they do not.

We've had individuals who voluntarily came in, so we could drug test them on companies that are trying to sell us test kits for flakka, say, "I just smoke flakka three days ago," we drug test them and it comes out completely clean, and it was a 10 out of 10.

We tried 10 different products and

none of them tested positive off this, and the difference in cost for a -- at least in Broward County, for the general marijuana, cocaine and amphetamine is about seven dollars and this synthetic one, I believe was $75.

So, for each person that you're testing, that's the difference in numbers, and you can only imagine what that does to a budget when you're trying to drug test so many people.

COMMISSIONER BREYER: I wanted to ask about the Florida experience and analog.

The analog is -- prosecutions on the analog, you've actually testified in state court on using that?

CAPTAIN TIANGA: I have not. We haven't even prosecuted on yet.

I'll tell you this. One of things, since you gave me a second, I was -- the DEA sent me and a team to China to meet with the Chinese government, and this was when flakka was so prevalent. We were basically begging them to

make flakka an illegal substance in China.

From that trip, they made 116 synthetic substances illegal immediately. Before we even arrived to their country, the substances were banned, and it read great in the papers and it was a tremendous accomplishment for us, but there was another 1,000 that came the next day. The variations are so minute, just molecular. The science behind it is so difficult to comprehend, that there has to be some sort of umbrella that captures it all, and I wish I had the answer for you.

But it just changes. By the time we utter it out of our mouths, they've already changed it.

ACTING CHAIR PRYOR: I'm sure the next panel will have an answer on this.

CAPTAIN TIANGA: Good.

DR. CUNHA: Looking forward to that one. Could I also say just one more thing?

Dovetailing to Dr. Rawlings, in my

experience, and a lot of the medical practitioners in Broward County that have dealt with these patients, especially the flakka and cathinone patients, they're very poor responders to therapy.

They're very poor responders to group therapy because they're very paranoid. For some reason, this class of cathinones causes a paranoia that's long lasting.

So, if you send them to an out-patient group setting to get drug rehabilitation, they often can't tolerate and don't go.

So, there again, resource-intensive even after the fact of their acute intoxication, and that makes them poor candidates for things such as supervised out-patient programs.

COMMISSIONER BARKOW: I'm not sure if you would have knowledge of this. But do you know if the -- do we have good information about the dose -- like the average dose of these things or is there such high variability that it will be

hard to say what kind of typical dose weights are or measuring it, because at some point down the line, we have to get to that point, and it sounds like there's high variability here.

CAPTAIN TIANGA: There is no regulation behind it, and she did mention it, that there will be a bad batch, and we've had it.

We've had communities, Oakland Park, Pompano, where everybody is using the drugs, but you'll have one specific community that everybody is overdosing and we just call it the bad batch.

The bad batch today went to Oakland Park or they'll change -- so, drug dealers in that area will now change the color and they'll make it pink Flak, Flak being short for flakka. They'll start selling pink Flak in the Oakland Park area.

Couple people will use it. We'll say, okay, well this -- you -- search for the pink flakka because the pink flakka is the safe one, it gets the highs and it doesn't cause excited

delirium, or it just takes the drug dealers down the street add a little food coloring to his, and now you have pink flakka ravaging the community, and again, you'll have another section of your community getting extreme, extreme overdoses. I'm talking about multiple overdoses a day, multiple overdoses where he would have to quarantine these people in this hospital and there is just nowhere to quarantine them.

So, we get two a days, where I take them to the hospital, the doc -- they would subdue them. Paramedics would subdue them. Take them to the hospital. The hospital -- once they wake up they say, "I'm out of here," they sign their -- their release. They come out. They re-overdose and we're back, in one shift, in one police shift, multiple times you'd have one person go to the hospital on an overdose twice.

DR. CUNHA: There's huge batch-to-batch variability. We have some great pictures in the presentation that we give, where they're

using -- it shows someone making synthetic cannabinoids, and there is what looks like saw dust all over the floor in a 12 by 12 room, and there is someone with an industrial bug sprayer, spraying the active ingredient onto this stuff that looks like saw dust.

So, this batch over here might be very intense. This batch over here may not be, and it's all packaged and sent out.

So, I can't give you a dosing, you know, scheme on that.

CAPTAIN TIANGA: Right now, under the analog law, they've mirrored the synthetic drug that it is mimicking.

So, for instance, the state law in Florida, four grams of heroin is trafficking. So, in turn, four grams -- and they're having big problems with non-pharmaceutical fentanyl because it didn't capture in all the legal jargon they had.

So, four grams, it would just match

it. So, if the drug mimics the effect of cocaine, then the trafficking sentences mimic the same as cocaine.

It doesn't really work. It's the best thing that they can come up with because it was literally an emergency. We needed sentencing now. I'm sure it will get better. But that's where it's at right now.

COMMISSIONER BREYER: Are there purity levels? Are there -- I mean, you get a kilo of flakka, is it -- gee, it's 90 percent or is it --

CAPTAIN TIANGA: No, not that I know of. I'm not scientist.

COMMISSIONER BREYER: It either got -- it is or it isn't and that's the --

DR. CUNHA: I'm sure that there is some one -- you know, one box that you get may be 65 percent and one box may be 75 percent. But I'm pretty confident to say that does the -- the drug pusher is not testing his batches to see

which one is good.

COMMISSIONER BREYER: So, it's not cut down, as some other drugs are cut.

CAPTAIN TIANGA: No.

DR. CUNHA: No.

CAPTAIN TIANGA: They're not. In fact -- in fact, they're cut -- the non-pharmaceutical fentanyl is cut down only to make it less potent because in its purest form, it's too potent for the user to use.

ACTING CHAIR PRYOR: Thank you. We're going to break for lunch, and we'll come back at 1:15, and we really appreciate you traveling here today, and your presentation.

(Whereupon, the above-entitled matter went off the record at 12:10 p.m. and resumed at 1:20 p.m.)

ACTING CHAIR PRYOR: The witnesses for our final panel will discuss the chemical structure and pharmacological effects of synthetic drugs.

Dr. Gregory Dudley is the Eberly Family Distinguished Professor and Chair of the C. Eugene Bennett Department of Chemistry at West Virginia University. Previously, he was on the faculty and the Department of Chemistry and Biochemistry at the Florida State University.

Dr. Terrence Boos is the Section Chief of the Drug and Chemical Evaluation Section, Office of Diversion Control, Drug Enforcement Administration.

Dr. Boos's responsibilities include managing a multi-disciplinary group of scientists.

And finally, Dr. Rick Doblin founded multiple -- multi-disciplinary association for psychedelic studies, MAPS in 1986. This is one time I'm happy to use the acronym, to help develop legal context for the beneficial uses of psychedelics and marijuana.

Under Dr. Doblin's research -- leadership, MAPS is currently funding clinical

trials of MDMA as a tool to assist psychotherapy for the treatment of post-traumatic stress disorder, PTSD. So, Dr. Dudley.

DR. DUDLEY: Okay, thank you very much for the opportunity to come here and speak with you today, and for considering my opinions. I've provided a written statement that you should have received, so, I'm not going to read from that statement.

I will mention that it focused on three sections, three parts, all towards the aim of what I hope will be some helpful contributions towards improving and strengthening the sentencing guidelines, towards the aim of having them be as logical and consistent as possible, at least when it comes to drug sentencing, based on principles and logic of medicinal chemistry.

In my experience, both in working with medicinal chemists and in working with the courts in sentencing hearings, I see that there is an underlying logic to the drugs, as listed in the

sentencing guidelines, that is based on the chemical structure and pharmacological effects that -- as covered medicinal chemistry.

So, the first part of my written statements point to a focus on areas where I feel that there is some ambiguities or inconsistencies that could be resolved, in particular what I perceive to be a discrepancy between how THC and marijuana are treated in the guidelines versus how they are presented in -- in nature, where current batches of marijuana, as I understand it, are on the order of 10 to 15 percent THC, whereas the ratio in the guidelines for THC is 167 to one with respect to marijuana, which would be more consistent with a .6 percent or six parts per 1,000 concentration of THC in marijuana.

Because a lot of the new substances are compared based on medicinal chemistry principles to listed substances like THC or marijuana, where there are inconsistencies it leads to confusion, right, and I'll highlight the

one particular hypothetical and how that would be played out with different -- and how that would -- how different interpretations would lead to different sentencing outcomes.

There are also some ambiguities that have come up in terms of how drug mixtures are treated and as well as -- well, I'll come back to the other thing here.

So, the second point that I focused on is something that I think was part of the Committee's charge here, and that is to look at new, emerging synthetic drugs, particularly the synthetic cathinones and the synthetic cannabinoids.

I heard some discussion this morning about the challenges at the regulatory stage with the analog enforcement act, and how to cover these particular substances at the enforcement phase.

I think at sentencing, we've already resolved the enforcement issue. The substances

in question are -- are known and their legal status is already known because that's been covered at the -- at the trial, which makes the notion of a categorical coverage simpler from the sentencing guidelines perspective.

So, in my written statements I've laid out a -- some ideas for categorical coverage of synthetic cannabinoids and categorical coverage of synthetic cathinones, and proposed what I consider to be reasonable and appropriate ratios based on comparison and context to other substances that were listed in the guidelines.

The final point that -- the brief point in my written statement was just to raise the issue or to echo the issue that's already been raised about using marijuana as the equivalency standard in the guidelines.

I understand the logic behind having an equivalency standard. Marijuana is complicated because it is a heterogeneous substance and can vary from batch to batch.

So, we're comparing new substances to something that is something of a moving target, and so, I would -- I would suggest a departure from the marijuana equivalency ratio, but I won't say anything more about that.

With my time here today, I wanted to focus on hypothetical sentencing involving one kilogram of a synthetic cannabinoid substance, produced and distributed in the context of synthetic marijuana.

Synthetic marijuana, while I understand the aversion to the term and from the scientific community, in the street sense, synthetic marijuana is a product that is intended to mimic marijuana in its appearance and its consumption and its effects, and as such, a logical comparator to synthetic marijuana in the guidelines would be marijuana, and I discuss that in my report.

What I want to do is talk about the different alternatives that could be presented in

the current guidelines, that might be resolved by a categorical listing of synthetic cannabinoids, as well as specific examples of synthetic cannabinoids.

So, for example, if one were convicted of a crime involving a kilogram of JWH-018, that substance could be found either pure in the white powder form, or already absorbed onto plant material and according to the DEA notification of what is a -- there is no standard recipe, but what is a common recipe is roughly 14 kilograms of synthetic marijuana could be produced by a kilogram of JWH-018.

So, one might have a kilogram of JWH-018 in pure form, or 14 kilograms of a product colloquially referred to as synthetic marijuana.

Those products, each case involving one kilogram of the synthetic cannabinoid substance could be compared to THC or compared to marijuana. It could be weighed as one kilogram or as 14 kilograms.

So, to me all -- this scenario should result in the -- in a single -- in a direction -- a guidance to a single sentence.

But in fact, what could occur and I believe has occurred in different cases around the country, is that kilogram of synthetic marijuana has been compared to marijuana directly, a kilogram of JWH-018 has been compared to marijuana directly.

The kilogram of JWH-018 has been compared to THC and then applied 167 to one multiplier or the JWH-018 might have been converted into synthetic marijuana to make 14 kilograms and then applied the 167 to one multiplier, to come up with a marijuana equivalency of 2,338 kilos.

So, that one kilo of JWH-018 could be sentenced as it if were a kilogram of marijuana, all the way up to 2,338 kilograms of marijuana, and that's an ambiguity and inconsistency that I think would be resolved by listing JWH-018 in the

guidelines, and I would recommend marijuana equivalency ratio for it of 14 to one, to reflect the amount of synthetic marijuana product that in principle can be produced from one kilogram of JWH-018, and this is consistent with the guidelines reflecting the object of the -- of the intent, being the target -- or the object of the intent being what the court should consider.

So, if the object of the intent -- the object of one kilogram of JWH-018 is to produce 14 grams of a substance that mimics the appearance and effects of synthetic marijuana, then that one kilogram of JWH-018 should be equated to 14 kilograms of marijuana.

Now, there are other considerations. Certainly, synthetic cannabinoids are not the same as THC, and I think there are other things that would go into the ultimate discussions here, but I think as a starting point, and especially if the guidelines are going to provide the structure for new substances to be compared using

a logic of medicinal chemistry, we'd want the ratios given in the guidelines to reflect the logic of medicinal chemistry as closely as possible, with perhaps text elsewhere to give guidance on when it might be appropriate for upward departures or downwards departures.

I see the red light is on and I apologize for going over. Thank you for allowing me to continue that train of thought to the end.

ACTING CHAIR PRYOR: Thank you, Dr. Dudley. Dr. Boos.

DR. BOOS: Good afternoon, Judge Pryor and members of the United States Sentencing Commission. Thank you for the opportunity to represent the Department of Justice today.

I'm going to briefly discuss synthetic drugs and the impact on public health and safety. I'd like to highlight some important points from the Department of Justice position that were in the paper provide to the Commission, on the five substances.

Our section at DEA evaluates information on substances of abuse, we collect the information and we initiate regulatory controls to protect the public where appropriate.

Unfortunately, we are able only to respond to the most persistent and harmful of those substances that are out there, there are many of these substances, and we took action on the five that are being considered right now by the Commission.

We have also provided testimony at federal prosecutions and sentencing hearings, our scientists do. Starting in 2009, the United States experienced a dramatic increase in trafficking and abuse of these drugs, that are intended to mimic traditional substances of abuse.

Across the board, I think we've heard from other speakers today, these substances have negatively impacted the user and the communities, and it continues.

The substances being discussed have no approved medical use and lack information to safely allow them to be given to humans.

However, the traffickers of those substances continue to put the public in harm's way by distributing these substances with unpredictable side effects.

To increase our knowledge of how these substances of abuse act, our scientists work closely with the National Institute on Drug Abuse and other experts to establish study protocols, to delineate these novel drugs and then determine their pharmacological simple areas with other known drugs of abuse.

These studies are the gold standard and DEA is fortunate to draw upon the expertise of those leading the field in these studies.

Numerous pharmacological studies have been entered -- undertaken with the assistance of our federal partners for these substances being discussed today.

These substances -- these studies have enhanced our understanding of the effects of these substances and are intended to complement the scientific literature.

Currently, our scientists in our drug chemical evaluation section were required to testify at the sentencing hearings in order for a court to determine what substance's guideline is most similar to the newly controlled substances, or potentially that analogue that have already been prosecuted.

These hearings are resource-intensive. Often DEA must provide both the chemist and the pharmacologist to testify at a given hearing. Similar, the defense calls an expert who also testifies at these sentencing hearings.

These contestant hearings require courts to consider complicated scientific evidence. Even after one court reaches a conclusion about a guideline comparison, other

courts can do and re-litigate the issue, sometimes with disparate results.

Provided information regarding the comparison of these substances to cannabinoids and cathinones will assist courts, prosecutors, defense attorneys to provide greater certainly for all involved.

In addition to the synthetic cannabinoids and cathinones being discussed today, MDMA continues to be a serious drug of concern, and the root of MDMA's widespread popularity is the mistaken belief that it's a safe drug with little toxicity. In fact, MDMA is an addictive psychoactive substance with unpredictable results.

In 2001, the U.S. Sentencing Commission established MDMA guidelines based on research that demonstrated the long term dangers to users.

Since then, the science has been strengthened by ongoing research, utilizing more

precise measurements which further conclude that MDMA is a neurotoxic danger to the user.

I'd like to thank you again for the time today and if you have any questions, I'd be happy to answer them.

ACTING CHAIR PRYOR: Dr. Doblin.

DR. DOBLIN: Thank you. I'll just add that I've had a Master's and PhD from the Kennedy School of Government, in the regulation of the medical use of Schedule I drugs.

Thank you very much for having me back here, after testifying 16 years ago in 2001, with other colleagues about the evaluation of the scientific research around the risks and benefits of MDMA, both in clinical context and in non-medical settings.

Our views were largely discounted at the time, in favor of risk estimates about MDMA, but it has since been shown, according to the last 16 years of scientific research, to have been excessive.

There was images of holes in the brain, all sorts of things that were not actually accurate. There are now over 5,000 papers in Medline on MDMA or ecstasy, and it's one of the most well studied substances that we know of, probably about $350 million of research has been spent, mostly looking at the risks of MDMA.

According to Dr. Paul Hofer, a policy analyst at the Federal Defenders and the author of a paper 'Ranking Drug Harms Through Sentencing Policy', the Sentencing Commission guidelines now penalize MDMA more severe than PCP, LSD, methamphetamine, heroin and powdered cocaine.

Two federal courts have since concluded that the MDMA guidelines need not be followed because MDMA's sentencing severity was found to be disproportional to MDMA's actual harm.

I'm deeply grateful for this new opportunity, after 16 years, to present written and now, this oral testimony, today in your

deliberations reviewing the current sentencing guidelines for MDMA.

To begin with one of our court reports from a few PTSD patients from our MDMA-assisted psychotherapy studies, to give you a sense of how pure MDMA can be used in a beneficial way with a high safety profile in controlled clinical settings, and there are some relationships between the work we're doing and risk estimates for use in non-clinical settings.

MDMA-assisted psychotherapy works by allowing the participant to address the root cause of his or her trauma in a safe and supportive manner and re-process that trauma without the debilitating associations of fear and anxiety.

MDMA reduces activation of fear in the amygdala, which allows participants to revisit past traumas without the emotional re-activity normal in PTSD, and this also explains why it has a widespread use in the non-medical settings.

One study participant, military Veteran C.J. Hardin explained in the New York Times in November of 2016, “MDMA changed my life. It allowed me to see my trauma without fear or hesitation and finally process things and move forward. Before I just felt hopeless and in the dark, but MDMA sessions showed me light I could move toward. Now, I'm out of the darkness and the world is all around me.”

Another veteran Jonathan Lubecky wrote, “I cannot emphasize how much this treatment changed my life. I went from constant, daily, suicidal ideation, anxiety and depression to almost nothing. The best part was this was not life-long treatment and medication, but that means that we only administer MDMA three times within a three and a half month process of more or less, weekly, non-drug psychotherapy.”

Another -- another study participant, Hania Witham who survived sexual assault recounts, “for the first time in my life I was

able to actually look at everything I had been running away from my whole life. That pretty much changed everything for me.

I feel like the luckiest person in the world because I think I've been given something that very few people have, which is a second chance to create the life I want."

Since 2001, my non-profit MAPS has sponsored nine FDA-approved drug development studies evaluating the safety and efficacy of MDMA-assisted psychotherapy for PTSD, for anxiety associated with life threatening illness and for social anxiety in autistic adults, at research sites across the U.S., Switzerland, Canada and Israel.

On November 29th, 2016, MAPS had an FDA end-of-Phase-II meeting and the FDA approved the move to large scale Phase III trials, for MDMA assisted psychotherapy for severe PTSD, final phase of research required for full FDA approval for prescription use.

FDA's green light for Phase III studies was based on the results of meta-analysis from Phase II pilot studies in 107 chronic treatment-resistant PTSD subjects, at the 12 month follow up after the last MDMA session, two-thirds of them no longer had PTSD, and we're working with leading VA-affiliated researchers, blending MDMA with existing non-drug psychotherapy for prolonged exposure and cognitive behavior and conjoined therapy.

We anticipate completing Phase III in 2021, after evaluating at least 300 more subjects with the goal of obtaining approval from the FDA in the European medical agency.

Though MDMA has a favorable risk-benefit ratio in clinical settings, what does this mean for the risks of MDMA in non-medical settings?

There are tragic, but fortunately, very rare outcomes from overheating and dying after consuming MDMA, usually after dancing in

hot, crowded spaces. Even rarer are cases of people drinking too much water after taking MDMA and dying of hyponatremia.

However, with simple public health harm-reduction-policies, access to free water, and better education, those harms can be minimized significantly.

Despite the lack of proactive reduction measures, emergency room statistics from 2001, most recently available data, show that MDMA-related emergency department visits only amounted to 1.8 percent of drug or alcohol related visits that year and the majority of these cases were acute psychological distress and most cases resolved after supportive care.

Additionally, some fraction of non-medical users of MDMA use it quite often for periods of a year or two, with such use almost always self-limiting, due to the diminishing subjective effects of MDMA. With normally addictive drugs, when tolerance developed, users

just take larger amounts. With MDMA, that fails to restore the earlier effects, but produces more side effects.

We don't see long term decades of abuse patterns the way we see with cocaine and methamphetamine and other drugs.

The main concern about repeated use has been focused on neuro-cognitive effects, since there are no significant harms to the body that have been reported.

In 2001, Dr. John Halpern at Harvard-affiliated McLean Hospital conducted a NIDA-funded study that demonstrated minimal impaired cognitive performance in heavy ecstasy users. This was the most methodologically sound study ever conducted on heavy Ecstasy users, we actually found population of people in Utah, we call them Mormons, who had not done any other drug, but had only done ecstasy. So, this was a good way to separate out what the ecstasy did.

While non-clinical use of ecstasy can

be problematic for some people, there are thousands of people who experience healing benefits from MDMA even when taken outside of clinical settings.

A 2014 a British documentary tells the story of Vietnam Veteran Dr. Bob Walker who decided to take MDMA outside of clinical settings for self-healing, and reported of overcoming decades of PTSD, calling it a cure.

Thanks to a comprehensive review and periods of scientific research into the risks of MDMA published since the sentencing guidelines were increased in 2001, data from MAPS's multi-site studies of therapeutic risks and benefits of MDMA and hundreds of anecdotes of self-healing from non-medical users of MDMA, it is clear that the sentencing guidelines are disproportionate to its potential harms. Thank you.

COMMISSIONER BREYER: Well, Dr. Dudley, I wanted to ask you in light of your testimony, is it your view that -- and putting

aside the synthetics for a moment, but let's just take the non-synthetics that we're dealing with.

Is it your view that our chart, our tables and so forth are flawed in some particular way?

DR. DUDLEY: There are particular places where I see some consistencies or ambiguities.

In general, I think that the chart is quite logical and reasonable, and I gave a couple of examples of this in my written report, relating to Psilocin or Psilocybin versus wet mushrooms versus dry mushrooms, where to a first approximation, whether you're dealing with a gram of Psilocin as a pure substance, or incorporated into wet or dry mushrooms, with those -- at those -- high -- you know, so wet mushrooms will have a lot of other stuff besides the pure Psilocin, and but the -- the dose of Psilocin is logically connected to the sentence, if that makes sense.

Same thing with Mescaline and --

COMMISSIONER BREYER: Right, but these are --

DR. DUDLEY: Yes.

COMMISSIONER BREYER: That is --

DR. DUDLEY: And I think that's the --

COMMISSIONER BREYER: That's the object of our --

DR. DUDLEY: Yes.

COMMISSIONER BREYER: -- of our inquiry is to make sure when somebody comes in and says it's -- the weight is x and the drug is y, that judge is going to look at a table and say well, that's how serious this is.

DR. DUDLEY: Right and so, for something like --

COMMISSIONER BREYER: Level 23. It's Level 21. It's level whatever it is. I mean, that's our task. We're not chemists. We're -- well, we all joke as we're sentencing accountants, but we're trying to figure out, you

know, where it is, and so, the chart is very important for us and for everybody, that the chart accurately reflects the harm that the drug causes.

DR. DUDLEY: Right, and the case of mushroom and Psilocin, the case of Peyote and Mescaline, the chart accurately reflects the amount of active ingredients in the various doses.

In the case of THC and marijuana, however, it does not. Marijuana, a gram of THC is these days, found generally in about seven or eight grams of marijuana.

So, if you have about seven or eight grams of marijuana, you have in your possession, about a gram of THC. That THC is equated in the marijuana equivalency tables to 167 grams of marijuana, and that discrepancy first of all, is a problem in treating -- this is an inconsistency with respect to THC and marijuana.

But then when you have new cannabinoid

substances coming in, that can ambiguously be compared to THC or to marijuana, that choice makes a huge difference in the sentencing.

COMMISSIONER BREYER: So, that's a -- but I'd like to ask sort of a larger question and get the DEA involved in this.

We heard all this testimony today that if you tweak it, tweak the molecules to something different --

DR. DUDLEY: Yes.

COMMISSIONER BREYER: -- that's not covered. So, one question is -- is even though you may sit today and try to take these five drugs and so forth and do something, only on a fool's errand in that -- in that we spent all this effort and tried to get it right, and then it becomes meaningless because the sellers out there or the producers could change it, and is there a way that you suggest that we could approach this problem, that it -- such as the two of you? I don't know.

DR. BOOS: I think we have a large task ahead of us. Obviously, we have -- we have emergency control plans in place to tackle the most persistent and harmful ones.

But under the guidelines, we still have a limited number of comparable drugs. We need to allow for more comparators, ones that are more clearly reflective of what we're dealing with currently, in the moment.

But we do have an issue where a substance by substance comparison is a challenge and I think at the DEAwe've looked at this and we are looking at some of our options to, and would be happy to suggest to DOJ.

COMMISSIONER BREYER: Yeah, I'd love to hear some.

DR. BOOS: I think Dr. Dudley touched on that. If it's a possible, a class approach where you look at the synthetic cannabinoid class, the cathinone class, benzodiazepines as a class and you find a range within that class that

would be appropriate --

COMMISSIONER BARKOW: But when we do that, in terms of -- since it can be -- the dose can be in different kinds of formats, what we heard earlier, so it could be sprayed onto plant material or it could be powder.

How would we reflect the dose or the weight if we did a class-based approach, so that it reflected that variation that you could have in the actual case, depending on if any of you have a thought on how to do that.

We had lots of comments about how in other areas, using the weight of a mixture, we get comments from the defenders, that leads to disparate results because we're using weight and you know, that can -- for things that the -- whatever substance it's adhering to weighs a lot, we may have sentences that are out of whack, and so, I'm concerned that this is the kind of drug that we can have that same problem with given the various forms that it takes.

DR. BOOS: And we have some similar examples now, when we deal with heroin and cocaine in the purity of those drugs and what the count is -- the count of the drug at sentencing.

DR. DUDLEY: I think what you --

DR. BOOS: It's the overall weight of the drug at sentencing, at that time.

COMMISSIONER BARKOW: Right, but for this class of drugs, I guess the concern would be the weight is going to be so variable depending upon what form it is, and it may not actually reflect variations in harm or in even the -- the effects on people, because it could just be something, the substance that it's adhered to.

The issue is, is it worse in this context than it might be for some of those other drugs, that we might be concerned that we're getting bad --

DR. DUDLEY: If I may, I think the better for comparison for these substances, the cannabinoids, rather than referring to heroin or

cocaine, where there is a substance on the street that may have varying purity, but is still viewed and sold as cocaine.

Here, I think the better way to look at this as two separate types of drugs, the pure substance and then the synthetic marijuana substance that has been absorbed onto inert material.

Similarly, just like Psilocin and mushrooms are listed separately, and Mescaline and Peyote are listed separately, THC and marijuana listed separately, you might list the synthetic cannabinoid pure substance actual, separately from the substance sold on the street absorbed onto plant material that is intended to mimic marijuana.

COMMISSIONER BREYER: So, what the -- the sentencing then -- would devolve to a chemical analysis, as to the -- I would call it the purity of the drug, but that may be the wrong word. It may be the dilution or the --

DR. DUDLEY: Well, it would be -- a sentencing --

COMMISSIONER BREYER: I mean, I'm just trying to figure out what judges are supposed to do.

DR. DUDLEY: So, there is -- you would typically see either the pure substance or some -- the white powder substance. I shouldn't say pure because it could be 60 percent pure, 70 percent pure, but the white substance that is not in its marijuana-mimicking smokable form, or you might be dealing with a material that has already been manufactured into the synthetic marijuana product that is a leafy substance.

So, if you're dealing with a leafy substance that has been infused with a synthetic cannabinoid, that would be one type of substance where you would be treating -- you would be thinking of that as a marijuana mimic.

The pure powder substance might be intended to be produced, to be used to produce

synthetic marijuana, but by itself might not be appropriate to compare to marijuana directly. Does that make sense?

COMMISSIONER REEVES: It does, but I'm not sure it's logical. It's in the pure form, I'm assuming that the user would not be using it in the pure form, but would be in a mixture form, and it could be more deadly in the mixture form because of that, because the user does not know what purity level it would be.

DR. DUDLEY: Right, so, I'm suggesting that the mixture form should be treated differently than the purer form.

COMMISSIONER REEVES: Should be treated more severely, I'm assuming.

DR. DUDLEY: Well --

COMMISSIONER REEVES: Based on that theory.

DR. DUDLEY: -- or less severely based on the --

COMMISSIONER REEVES: The pure form -

- it's more dangerous to have this -- spray it on a plant, let's say, and the level is very high and it's very dangerous.

DR. DUDLEY: The level in the, you know, ounce for ounce, the level in the mixture is going to be lower than the level in the --

COMMISSIONER REEVES: But nobody is -- it's dangerous because the person would be more inclined to use it in that form rather than in pure form.

DR. DUDLEY: But the person -- right, the person that is going to use it -- the end user is likely to be using this as -- the same way one would use marijuana, that would be smoke it.

COMMISSIONER REEVES: But then --

DR. DUDLEY: But if someone has --

COMMISSIONER REEVES: -- a very potent substance, it could be very dangerous to the person.

DR. DUDLEY: Well, okay. So, the

substance itself could be regulated as a synthetic cannabinoid and it could be scheduled as to reflect this potency or it's -- yes, its potency, I guess, or its potency.

The synthetic marijuana product, the way that the marijuana is typically sentenced is independent of the strain of marijuana and the level of THC in it, which is an imperfection, but not one that -- it's going to be difficult to resolve, all right, because the -- the extra lab work that would go into establishing the level of THC in different quantities of marijuana, that cost may or may not be justified.

If it is, that's fine and likewise, if one wanted to go to the extra steps, to identify the level of the new synthetic cannabinoid in the THC -- in the marijuana, so if you had a kilogram of synthetic marijuana, one could go the extra step and determine exactly how much of the active ingredient is present and then sentence according to the amount of that active ingredient.

But if one were going to sentence according to the amount of the synthetic marijuana product, assuming that the product was manufactured to mimic the effects of marijuana and intended for an end user to smoke it, then the reasonable comparator in the guidelines at that point would not be heroin, cocaine or THC, but rather marijuana itself, and that's where I was going with the two separate -- there is the synthetic marijuana product and the synthetic cannabinoid product that would ultimately be used in the manufacture of synthetic marijuana, and I think those -- I think the cleanest, thing, the easiest thing would be to treat those separately in the guidelines, but there are logical ways to do it either way.

DR. BOOS: If I could add onto that. If you want to take the amount of the drugthat would be on the plant material that would be extremely challenging for the forensic laboratories.

Right now, the experience, whether it

be local, state or federal levels, there's a huge backlog of analyzing drugs. Usually they're put on rush when something goes to trial.

But for them to go through and have to quantitate how much synthetic cannabinoid is on that plant material, it would be problematic.

COMMISSIONER BREYER: So, you're saying it -- just -- it would be impractical to do it.

DR. BOOS: Right.

COMMISSIONER BREYER: But in every -- every -- every drug case, I mean, I just see them, every drug case, it would go to the lab, both sides would be able to conduct their own analysis, and they're rather expensive propositions, aren't they, to conduct this analysis? I don't know. Are they?

DR. DUDLEY: I agree with Dr. Boos. It is -- it would be impractical. It would be expensive, and clearly that's not what I'm suggesting either.

I think we don't treat marijuana differently, depending on how much THC is in a particular strain, and it would be very expensive and problematic, to attempt to treat synthetic marijuana differently, depending on which and how much of the particular synthetic cannabinoid was present.

I think a more pragmatic approach would be categorical coverage of the pure synthetic cannabinoid material that is intended for production and then categorical coverage of the synthetic marijuana material that is in distribution and use.

COMMISSIONER BREYER: When you say categorical coverage, what -- what you are suggesting is that we -- that will then take care of the problem of molecular changes, to some extent.

DR. DUDLEY: It will for the purposes of sentencing.

COMMISSIONER BREYER: Well, that is

why we're here.

DR. DUDLEY: Right, and so, at sentencing, we heard testimony this morning about the complexities of the analogue enforcement and that dilemma that it poses for prosecutors and for police law enforcement.

At sentencing, that matter has already been resolved, right? If you're at sentencing, then the substance in question --

COMMISSIONER BARKOW: Can I ask you, Dr. Boos, on that MDMA issue.

So, I get the still serious, still has all these effects, but what is your response to Dr. Doblin's point that it's sentenced -- you know, it's treated as a greater harm than meth or heroin. Is there is evidence to support that, the relative harm of the drug, as compared to other drugs?

Do you have basis for assuming it's worse than those other drugs?

DR. BOOS: You know I looked at the

comparison of methamphetamine, which is actually a Schedule II drug and it's approved as medication.

But it's one-to-2,000 under the guidelines MDMA is oneto-500. It's not an approved drug. Dr. Doblin is talking about it with respect to select clinical trials that they're conducting. It's still hasn't been approved by FDA as a therapeutic. Hasn't been placed in another schedule -- it remains a Schedule I drug.

COMMISSIONER BREYER: From an enforcement point of view, there is -- does it really make any difference whether something is Schedule I drug, Schedule II drug?

DR. BOOS It's a violation of controlled substances.

COMMISSIONER BREYER: Well, it's a violation.

DR. BOOS: Now, Schedule I, obviously something with no approved medical use, it's

placed in Schedule I. All of II through V are all the substances with abuse and liability that have an approved medical use.

They've been evaluated. They have a proper safety profile that's taking place, and the FDA has approved them to be medications.

COMMISSIONER BARKOW: But other than the scheduling, do you have a basis for assuming that it's worse? Because the scheduling, for various reasons, some drugs stay where they are for political reasons and otherwise.

So, apart from that, is there scientific evidence for that?

DR. BOOS: I think the scientific evidence still tends to show that it's a harmful drug and some of what was sort of described is not accurate.

They exist. We know there are neuro-cognitive issues associated with the use of it. It's not used, it's used in a setting, it's not under the care of a physician, and clinical

trial, that's something completely different what we're talking about, and as we've seen with MDMA, that's a really good report out for upwards of 140+ milligrams of pills and these are heavy doses of drugs that are being trafficked.

DR. DOBLIN: I guess if I could just add one point.

I think there is no doubt that at certain doses, MDMA can be neurotoxic, but the doses that even at 140 milligrams are below those levels, and the doses that we use in therapy are 125 milligrams, followed two hours later by 62.5.

So, from the perspective of the FDA, these intermittent uses, the neurotoxicity is no longer an issue because there is corresponding benefits, and I think in most evaluations of the non-medical use of MDMA, people are using it because they experience benefits as well.

So, I do think that there are risks but a lot of the risks are controllable through harm-reduction policies and I don't think they

are anywhere near as severe as they have been portrayed in the past, and we also have now since the middle 70s, MDMA was used as a therapeutic drug.

So, we have about 40 years almost, or more of experience with MDMA, and so, the concerns that were expressed during the 2001, about sort of the time bomb theory of these neurotoxic effects, we didn't see really functional consequences of the severe nature that they would come with aging as people's brains were aging, that's not proven to be the case.

So, I think it's much more reassuring than it has been in the past.

ACTING CHAIR PRYOR: Okay, unless any of you have something else to add, I want to thank all of you for appearing today and offering your presentations, and of course, the written materials that you had already submitted. Thank you very much.

DR. DUDLEY: Thank you very much.

ACTING CHAIR PRYOR: That concludes our public hearing.

(Whereupon, the above-entitled matter went off the record at 2:00 p.m.)